

**AMA/Specialty RVS Update Committee
Meeting Minutes
April 24 – 27, 2003**

I. Welcome and Call to Order

Doctor James H. Hoehn called the meeting to order on Thursday, April 24, 2003, at 8:00 am. The following RUC Members were in attendance:

Dennis M. Beck, MD*	A. Clinton MacKinney, MD*
Michael D. Bishop, MD	James D. Maloney, MD*
James Blankenship, MD	John E. Mayer, MD
James P. Borgstede, MD	David L. McCaffree, MD
Melvin C. Britton, MD	Bill Moran, Jr., MD
Norman A. Cohen, MD	Bernard Pfeifer, MD
Thomas P. Cooper, MD*	Gregory Pryzbylski, MD
John Derr, Jr., MD	Sandra B. Reed, MD*
Lee D. Eisenberg, MD	James B. Regan, MD*
Robert Florin, MD*	William Rich, MD
John O. Gage, MD	Chester W. Schmidt, Jr., MD
William F. Gee, MD	J. Baldwin Smith, III, MD
Meghan Gerety, MD	Peter Smith, MD*
Alexander Hannenberg, MD	Holly Stanley, MD*
David F. Hitzeman, DO	Susan M. Strate, MD
James G. Hoehn, MD	Robert J. Stomel, DO*
Charles F. Koopmann, Jr., MD	Trexler Topping, MD*
George F. Kwass, MD*	Arthur Traugott, MD*
M. Douglas Leahy, MD*	Richard H. Tuck, MD
Barbara Levy, MD	Paul E. Wallner, DO
J. Leonard Lichtenfeld	Richard W. Whitten, MD
Charles D. Mabry, MD*	Don E. Williamson, OD

* Alternate

II. Chair's Report

Doctor Hoehn welcomed the RUC and made the following announcements:

More than 200 physicians, other health care professionals, and specialty society staff will be attending the meeting.

- Those observing the meeting include:
 - Kevin Hayes, Medicare Payment Advisory Commission (MedPAC) staff

- Barbara McAneny, MD, Practicing Physician Advisory Commission (PPAC) member,
 - Douglas Wood, MD, PPAC member, Chair of the AMA Evaluation and Management Guidelines Taskforce and Chair of the HHS Advisory Committee on Regulatory Reform
 - William Mangold, MD Medicare Carrier Medical Director/ Transamerica Occidental Life, Arizona
 - Teresa Ruiz-Law, guest of the American Nurses Association
 - Mary Knudtson guest of the American Nurses Association
- RUC Alternate – Clinton MacKinney, MD, will sit in for Neil Brooks, MD from AAFP. Other RUC Alternates will be announced as they are seated at the table.

- This is the first RUC meeting for two new members:

Michael Bishop, MD, American College of Emergency Physicians
Norman Cohen, MD, American Society of Anesthesiologists

- Several members of the RUC's Practice Expense Advisory Committee (PEAC) will be in attendance including:

James Anthony, MD	James Regan, MD
Joel Brill, MD	Daniel Mark Siegel, MD
Manuel Cerqueira, MD	Robert Stomel, MD
Neal Cohen, MD	Charles Weisman, MD
Mary Foto, OTR	Lester Wold, MD
Scott Manaker, MD	

- Several CMS Staff members will attend this RUC meeting to provide presentations on issues such as the practice expense zero work pool methodology and new technology. The following staff from CMS will be in attendance:
 - Thomas Scully, Administrator for CMS
 - James Bowman, MD, MBA, CMS Medical Officer
 - Jackie Garner, Regional Office Administrator
 - Edith Hambrick, MD, JD, CMS Medical Officer
 - Marc Hartstein, CMS Senior Technical Advisor
 - Paul Rudolf, MD, JD, CMS Medical Officer
 - Ken Simon, MD, MBA, CMS Medical Officer
 - Pamela West, MPH, PT, CMS Health Insurance Specialist
- Doctor Hoehn then recognized and thanked the following departing RUC members for their service to the RUC:

Mel Britton, MD	American College of Rheumatology
Lee Eisenberg, MD	CPT Editorial Panel
Paul Wallner, DO	American Society for Therapeutic Radiology and Oncology
Don Williamson, OD	American Optometric Association

- The Physician Open Door Forum will begin April 25th, at 1 pm (CST) and will last approximately 1 hour. This forum will be hosted by Mr. Scully from the RUC Meeting.
- The Rotating Seat Elections will begin promptly at 7 am on Saturday, April 26, 2003.
- All facilitation committees will meet on either Friday or Saturday evening – all reports will be given on Sunday morning, April 27th.
- Doctor Hoehn announced the members of the facilitation committees:

Committee I

Pre-Facilitation: Central Venous Access Devices (Tab 13)

Thursday, 7am – 9am

Melvin C. Britton, MD, Chair	Richard H. Tuck, MD
Meghan Gerety, MD	Paul E. Wallner, DO
Barbara Levy, MD	Richard W. Whitten, MD
John E. Mayer, Jr., MD	Lanny Garvar, DMD
Bernard Pfeifer, MD	David Keepnews, PhD, RN
William Rich, MD	

Committee II

David F. Hitzeman, DO, Chair	J. Leonard Lichtenfeld, MD
Michael Bishop, MD	Gregory Przybylski, MD
Norm Cohen, MD	Chester W. Schmidt, Jr., MD
William Gee, MD	J. Chris Nunnick, MD
Charles F. Koopmann, Jr., MD	Don Williamson, OD

Committee III

John Derr, Jr., MD, Chair	Bill Moran, MD
James Blankenship, MD	J. Baldwin Smith, III, MD
James P. Borgstede, MD	Susan M. Strate, MD
John O. Gage, MD	Arthur Traugott, MD
A. Clinton MacKinney, MD	Emily Hill, PA-C
David L. McCaffree, MD	

III. Director's Report

Sherry Smith made the following announcements:

- There were several mailings and handouts made to provide members with all information that will be discussed at this meeting, please make sure that you have all of this information. In addition to these handouts, several specialty societies were unable to get their information to AMA staff on time and therefore have brought their recommendations in the form of handouts to the meeting. These handouts are available through AMA staff.
- The September RUC Meeting will be at the Swissôtel in Chicago, IL. The February RUC Meeting will be at the Double Tree Paradise Valley in Scottsdale, AZ.
- The updated version of the RUC database was provided to all RUC members and is available through AMA staff.

IV. Approval of the Minutes for the January 31 – February 1, 2003

Dr. McCaffree made the following revision on page 13 the under the first paragraph describing the Mohs. The third sentence should read:

“In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the *site* and size of the lesion, rather than the number of specimens.”

The amended minutes were accepted.

V. CPT Update

Doctor Lee Eisenberg thanked several RUC members for attending the CPT meetings and learning about the CPT process. He also made the following comments:

- The CPT Editorial Panel Meeting in May and August are expected to have a small number of items for review.
- CPT Process for E/M Coding and Documentation Guidelines Workgroup – Over a year later, this project is entering its third phase, which is a the trial period that will allow several selected societies to draft clinical examples for pre-selected symptoms. Doctor Doug Wood was introduced to give further details on this process.

Doctor Wood delivered a brief update of the E/M Coding and Documentation Guidelines Workgroup which includes the formation of the Clinical Examples Task Force. The Clinical Examples Task Force is charged with developing the trial phase process and instructions for specialty societies to use in the development of their clinical examples. At this time, the Task Force has discovered several issues that need to be addressed within this process

including: 1) Work equivalence between the specialties, 2) Work equivalence to the existing E/M code, 3) Code level accuracy, and 4) Developing a system that will provide protection from audits for physicians. The Task Force is currently working to address these issues.

Several members of the RUC, who sit on the Task Force, reiterated Doctor Wood's comments about the issues that need to be addressed and added several other issues including that the role of the RUC in this process has not been clearly established, the timeline of the completion of this project, necessity of new documentation guidelines, the establishment of a clinical example validation process and the composition of the trial phase.

Doctor Wood acknowledged that the role of the RUC is very important to the Documentation Guideline Taskforce process and recommends the continued communication between the CPT Editorial Panel and the RUC concerning the Taskforce. He also addressed the timeline issue by stating that the Taskforce will not be rushed into creating another failed system. The Taskforce will take the time necessary to address all issues that could affect this new documentation guideline system. In addition, Doctor Wood stated that the purpose of the small composition of members in the trial phase is to identify from this smaller group the positive and negative aspects of the process that has been created by the task force. The Taskforce hopes to expand this process to all specialty societies after the trial phase has been assessed.

Doctor Hoehn reminded the RUC that in February the RUC had approved a motion stating that, "*Prior to the specialty societies being asked to develop clinical examples, the content and format of the template clinical examples and instructions should be presented to and approved by the RUC at a face-to-face meeting.*" This motion would need to be enacted at this meeting because the April RUC meeting is the last meeting before the instructions are to be sent to specialty societies.

The RUC has decided to table this motion until RUC members of the Taskforce have had a chance to review the proposed instruction document. Once reviewed by these members, these revised instructions will be presented to the RUC for its approval. Doctor Meghan Gerety briefed the RUC members on the editorial changes that were made by the RUC members serving on the CPT Documentation Guideline Taskforce to the original Taskforce's instructions to the specialty societies for developing clinical examples. These changes have been attached to these minutes. **The RUC approved the editorial changes to the CPT Editorial Panel's Evaluation and Management Workgroup's Instructions to National Medical Specialty Societies on the Development of Clinical Examples for Evaluation and Management Services Designated as Reference Services document.**

VI. CMS Update

Doctor Rudolf introduced two new physicians that have joined CMS: Edith Hambrick, MD, JD and Jim Bowman, MD.

Doctor Paul Rudolf introduced Marc Hartstein, Senior Technical Advisor to CMS. Marc Hartstein has expert knowledge regarding practice expense methodology and will present on the effects of new technology on reimbursement.

Marc Hartstein's presentation highlighted various topics including budget neutrality and how it is calculated for work RVU and practice expense inputs. During his presentation, Mr. Hartstein emphasized the importance of utilization data collected by specialty societies on the Summary of Recommendation Form. This information is instrumental in achieving budget neutrality for both work and practice expense inputs. He explained that the utilization of the existing codes aids in determining the utilization of new codes and existing codes for the following year. He concluded by discussing how this utilization information in combination with the budget neutrality adjustor and existing physician work is instrumental in determining physician work and practice expense for new codes and existing codes.

RUC members enthusiastically received Mr. Hartstein's presentation and there were several comments and questions. RUC members have observed that with the advent of new technologies, the site of service for several procedures is shifting from the hospital setting to the office setting, affecting the physician fee schedule by 1) redistributing of payment among the specialties, and 2) increasing growth of total expenditures. RUC members believe these effects could have a significant negative impact on the other services currently being reimbursed by Part B. The RUC questioned the feasibility of several solutions to this problem including: shifting funds from Part A to Part B to account for shifts in site of service, or modifying the SGR conversion factor to an increase the Part B pool of funds. Other suggestions include considering the of service shift as a regulatory change or a new benefit.

Doctor Hoehn thanked Mr. Hartstein for his excellent presentation. He then introduced Tom Scully, CMS Administrator. Mr. Scully thanked the RUC for all of its input over the years and for the opportunity to present at this meeting. Mr. Scully reviewed the more controversial topics that CMS addressed last year and will address this year including the anesthesia codes, addressing the issue of drug pricing for drugs provided to oncology patients while determining the appropriate practice expense costs for the provision of these drugs.

Several RUC members thanked Mr. Scully for all of his efforts in fixing the Medicare conversion factor and ensuring a positive update. The RUC members acknowledged that without his commitment to this project, this

positive update would not have occurred. RUC members also commented on the strong relationship between the RUC and CMS and agreed that the representatives from CMS who have staffed the RUC meeting through the years have been instrumental in the success of the RBRVS.

Mr. Scully addressed several RUC member questions during the Physician Open Door Teleconference including:

- the mental health parity issue;
 - the possible effects of new technology allowing the site of service of a various procedures to shift from the hospital setting to the office setting;
 - the anesthesiology payment scale; and
 - prescription drug utilization being a part of the fee schedule.
-
- In addition, Mr. Scully addressed questions regarding the possible effects of new technology allowing the site of service of various procedures to shift from the hospital setting to the office setting. He stated that this is a very complicated issue because this would require removing money from Part A which has no cap and placing this money into Part B which does have a cap. This adjustment could only be made legislatively because CMS does not have the authority to add more money to Part B to compensate for a shift in volume. He continued by stating that CMS is very interested in studying payment differentials in various sites of services. He noted that there is often a payment level difference between physician offices, ASCs, and hospital outpatient settings that have a negative effect on selection of site of service.
-
- Mr. Scully addressed CMS's plan for addressing the professional liability insurance costs issue. He recognized that premiums have increased in certain areas of the country and in various specialties, resulting in many physicians leaving or moving their practices. This plan includes reviewing the physician fee schedule and updating the current PLI database. However, this component of the RBRVS makes up only 3% of the total relative value of all services and therefore will not completely solve this problem. To solve the problem, CMS continues to support and advocate President Bush's plan for PLI reform. Mr. Scully stated that this current PLI premium database will be available to the RUC if there is no proprietary information contained within it.
-
- Mr. Scully concluded by thanking the RUC for hosting the Physician Open Door Forum and for their participation in updating the physician fee schedule.

VII. Washington Update

Sharon McIlrath reviewed several legislative and regulatory issues:

- Medical Liability Reform- The House did pass an AMA-supported bill in mid-March to create a \$250,000 cap on medical liability. However, this bill has met resistance within the Senate. The Senate is requesting that this cap be raised to \$500,000. The AMA is working with the Senate to try to maintain the \$250,000 cap with a proposed provision added for catastrophic cases.
- Patient safety, regulation relief, mental health parity, health insurance for the uninsured, Medicare reform are all issues currently being addressed by the AMA and Ms. McIlrath offered to discuss these issues in more detail with any RUC members who were interested.
- Medicare Update- A congressional provision was made to raise the 4.4% negative update to a 1.6% positive update to the Medicare conversion factor. However, now the AMA is focusing on next year's Medicare Update. The formula CMS uses to determine the conversion factor is still flawed. The AMA is working to help correct this mistake, however, CMS has predicted that the update next year would be between and a +0.60% and a -5.8% update, most likely a -4.2% update. In addition, CMS has projected a negative update to the conversion factor through 2007. AMA, in response to this projection, has drafted a letter to MedPAC stating that a cause for these negative updates is due to the large increase in the volume of services being billed. The overall spending on all services including prescription drugs and laboratory services included in the Part B reimbursement pool has rose by 6.5% per beneficiary. The AMA is under enormous pressure to explain these volume increases. MedPAC, another group investigating the volume increases, has agreed with the AMA in its proposal to remove the SGR component from the conversion factor equation instead of having an expenditure target.

A table has been handed to all of the RUC members showing the projected changes from 2001-2002 in the SGR spending by type of service, place of service and specialty. AMA staff is requesting that the RUC members take this data, review it and give a rationale explaining these volume differences between 2001 and 2002. A group of RUC participants met with AMA staff to discuss the data on Friday April 25th.

Ms. McIlrath commented that Tom Scully, CMS Administrator, deserves special appreciation for all of his efforts on obtaining the positive Medicare Update in 2003.

VIII. RUC Rotating Seat Elections

The RUC implemented the voting procedures adopted at the February 2003 RUC meeting. The nominations for the Internal Medicine Rotating Seats were as follows:

Emil Paganini, MD

Renal Physicians Association (RPA)

Alan L. Plummer, MD	American College of Chest Physicians/American Thoracic Society (ACCP/ATS)
Satti Sethu-Kumar Reddy, MD	American Association of Clinical Endocrinologists (AAACE)
David H. Regan, MD	American Society of Clinical Oncology (ASCO)
Maurits J. Wiersema, MD	American Society of Gastrointestinal Endoscopy (ASGE)

The RUC elected Maurits J. Wiersema, MD, of the American Society of Gastrointestinal Endoscopy to the one internal medicine rotating seat, which will be a two year term.

The nomination for the any other seat rotating seats were as follows:

Stephen J. Chadwick, MD	American Academy of Otolaryngic Allergy (AAOA)
Michael Benjamin Edye, MD	Society of American Gastrointestinal Endoscopic Surgeons (SAGES)
Richard Kagen, MD	American Burn Association (ABA)
David A. Margolin, MD	American Society of Colon Rectal Surgeons (ASCRS)
Charles A. Mick, MD	North American Spine Society (NASS)
Daniel M. Siegel, MD	American Society for Dermatological Surgery (ASDS)
Sherry Barron-Seabrook, MD	American Academy of Child Adolescent Psychiatry (AACAP)
Robert M. Zwolak, MD, PhD	American Association of Vascular Surgery (AAVS)

The RUC elected Robert M. Zwolak, MD, PhD, American Society of Vascular Surgery, to the “any other” rotating seat which will be a two year term.

IX. Relative Value Recommendations – Requests from CMS:

Developmental Testing Services (Tab 5)

96110

CPT code 96110 describes limited developmental testing, not the routine preventative medicine developmental forms. The typical scenario is a parent will call concerning their child (i.e. concern of autism) and the pediatric office will ask the parent to come in and fill out a screening form, which will be scored by a nurse. The parent would discuss this at a future scheduled visit with the pediatrician. As this code only describes the administration of the

test, there is no physician work associated with this code, **the RUC recommends a work relative value recommendation of 0.00 for 96110.**

96111

The RUC examined code 96111 *Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour.* It was determined by the RUC after reviewing the reference code 99245 *Office consultation for a new or established patient, which requires these three components: a comprehensive history; a comprehensive examination; medical decision-making of high complexity* (Work RVU = 3.43) that the intra-service time of the surveyed code (intra-service time = 85 minutes) exceeds the intra-service time of the reference service code (intra-service time = 48 minutes). In addition, the RUC noted that the survey's complexity and intensity measures for the surveyed code were often higher than the reference code. Although the descriptor for 96111 clearly states that it is a "per hour" code, the median survey intra-service time was 85 minutes, which is counterintuitive to a code designed to be reported for each 60 minutes of service. Based on this survey anomaly, the RUC agreed that the 25th percentile is the appropriate recommendation since it has both an intra-service time of 60 minutes and a survey work RVU of 2.60, which approximates the current work RVU of 99244 (2.58), a lower level consultation code than the most frequently selected reference service code (99245). In addition, the RUC requested that the specialty develop a coding proposal to CPT to delete the language "per hour," so that the code descriptor adequately reflects the service. The RUC felt that this code should only be reported once rather than "per hour." **The RUC recommends a work relative value of 2.60 for 96111.**

Practice Expense

The RUC modified and accepted the direct practice inputs recommended by the specialty society for these codes which were based on PEAC accepted standards. The specialty society requests that CPT code 96100 not be included in the zero work pool.

X. Relative Value Recommendations for CPT 2004:

Anesthesia for Pelvic Acetabular Fracture (Tab 6)

James D. Grant, MD, American Society of Anesthesiologists

CPT Code 01173

The CPT Editorial Panel approved a new code to describe the provision of anesthesia for patients who have sustained an injury that disrupts the pelvic circle. These patients are typically multiple trauma victims with multiple and significant injuries and acute co-morbidities that directly influence their anesthetic care and a new code is needed to accurately describe the anesthesia work. The RUC suggested changes to the CPT descriptor to reflect that the

anesthesia is for acetabular fractures and the CPT Editorial panel subsequently agreed to the following descriptor for code 01173: *Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum*. The RUC felt that such a descriptor more closely matched the vignette used to value the code since the base unit value should reflect the anesthesia work involved with a trauma victim that requires complex anesthetic management.

The RUC focused on placing the new code 01173 in proper rank order with other ASA codes since the Anesthesia codes are valued on a different scale than all other codes in the RBRVS. The new code intensity measures were examined in comparison to the reference code 01215 *Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty*, (base unit =10) and determined that the higher intensity values for the new code supported a higher base unit. In addition, the new code was also compared to other anesthesia codes with base units of 15, such as code 00500 *Anesthesia for procedures on esophagus*. Other codes with base units of 10 were also examined, such as 01212 *Anesthesia for open procedures involving hip joint; hip disarticulation*. The RUC concluded that the best way it could value the new code was to compare it to the existing base units of other anesthesia codes and determining the proper rank order. The RUC concluded that a base unit of 12 placed this code in proper rank order with other anesthesia codes.

The RUC recommends 12 base units for code 01173.

Hyoid Myomectomy and Suspension (Tab 7)

James Denny, III, MD, American Academy of Otolaryngology – Head and Neck Surgery

The CPT Editorial Panel created one new code 21685, *Hyoid myotomy and suspension*, to describe a surgical procedure to help correct sleep-disordered breathing (obstructive sleep apnea syndrome) by functionally enlarging the retrolingual hypopharyngeal airway. There is no current code that adequately describes this procedure. The specialty society originally presented the code at the February 2003 RUC meeting. The RUC requested that the specialty society revise the code's vignette and re-survey the code.

Due to conflicts in scheduling the specialty society determined that it should hold off on its re-presentation of recommendations until September 2003. Given the relatively low volume of cases, the RUC and the specialty society agreed that CPT code 21685 should be carrier priced for 2004. A recommendation from the RUC will be submitted to CMS immediately following the September 2003 RUC meeting.

The RUC recommends the carrier price for CPT code 21685.

Transbronchial Biopsy Procedures (Tab 8)

**Alan Plummer, MD, FCCP and Scott Manaker, MD, PhD, FCCP,
American College of Chest Physicians/American Thoracic Society**

The CPT Editorial Panel created a number of editorial revisions and added two new add-on codes to the family of transbronchial biopsy procedures to provide specific guidance on the reporting of biopsy(s) for single versus multiple lobes.

The RUC considered survey data from more than 30 physicians and agreed that the nomenclature changes to CPT codes 31622-31628; 31630-31631; and 31635-31640 are editorial in nature and do not change the work of the service. In reviewing these changes, the specialty argued that there is currently a rank order anomaly between the work relative value for 31629 *Bronchoscopy, (rigid or flexible), with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work rvu = 3.37) and 31625 *Bronchoscopy, (rigid or flexible), with or without fluoroscopic guidance; with bronchial or endobronchial biopsy (s), single or multiple sites* (work rvu = 3.37). The specialty argued, and the RUC agreed, that the physician work for 31629 should be greater than 31625 as it is a more complex and riskier as the physician is placing the needle through either the trachea or bronchial wall. CPT code 31629 typically requires fluoroscopy, while 31625 rarely requires fluoroscopy. Fluoroscopic guidance is included in these services and not reported separately. The specialty informed the RUC that this code had not been surveyed in the past. The specialty presented the 25th percentile of 4.10 as the recommendation. **The RUC agreed and recommends a work relative value of 4.10 for CPT code 31629.**

CPT Codes 31632 *Bronchoscopy, rigid or flexible with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* and 31633 *Bronchoscopy, rigid or flexible with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* are new CPT add-on codes. The survey respondents indicated that these services typically require 18-20 minutes of additional time for each additional lobe. The specialty was concerned that the survey respondents did not fully understand add-on codes and may have over-estimated the physician work involved in the service. The specialty, therefore, recommends that the values for these services be derived as follows:

CPT code 31632 should be valued at the increment between CPT Code 31628 *Bronchoscopy with transbronchial lung biopsy(s)* (work rvu = 3.81) and CPT Code 31622 *Bronchoscopy base code* (work rvu = 2.78), which is 1.03. **The RUC agrees and recommends a work relative value of 1.03 for CPT code 31632.**

Exploratory Cardiotomy Codes (Tab 9)

Keith S. Naunheim, MD, Society of Thoracic Surgeons

The CPT Editorial Panel has modified the two existing exploratory cardiotomy codes to describe the work of a patient where the removal of an atrial or ventricular thrombus is required. Currently, it is becoming more common for the intracardiac thrombus to be removed rather than removal of a foreign body, particularly with the advent of percutaneous pacing lead laser-extraction systems. By adding this terminology into the exploratory cardiotomy codes, it is clear which code should be reported for the service. These changes to the CPT descriptors, however, were deemed by the specialty society to be editorial in nature and thus do not affect the work values associated with these codes. **Therefore the RUC recommends to maintain the work relative values of CPT code 33310 *Cardiotomy, exploratory (includes removal of foreign body, atrial, or ventricular thrombus); without bypass (RVU = 18.51)* and 33315 *Cardiotomy, exploratory (includes removal of foreign body, atrial, or ventricular thrombus); with cardiopulmonary bypass (RVU = 22.37)*.**

Repair of Infrarenal Abdominal Aortic Aneurysm; Prosthesis (Tab 10)

Gary Seabrook, MD, and Robert Zwolak, MD of the American Association for Vascular Surgery, Bibb Allen, MD, American College of Radiology

Based on new information regarding FDA approval and efficacy and safety, the CPT Editorial Panel determined that the request to transition Category III code 0002T to a new code Category I code 34805, *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aortouniiliac or aortounifemoral prosthesis*, was appropriate.

A coalition of several specialties, including vascular surgery, interventional radiology, and radiology, reviewed and surveyed the new CPT code 34805. A survey median of 21.88 was collected from 44 physicians, who indicated a pre-service time of 105 minutes, an intra-service time of 150 minutes, and a post service time of 161 minutes. The RUC agreed that in comparison to the reference service code, 34800, *Endovascular repair of infra-renal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis (RVU=20.75)*, the new service has 30 minutes more intra-service time. In addition, the RUC considered the intensity and complexity measures for the reference code, which were slightly higher for the new service, reasonable because both require precise attention to accurate deployment at renal artery origins. The extra intra-service time of the new service is due to the work required at the iliac drop zone. However, the RUC questioned the post-service time and determined that one 99212 and one 99213 office visit should be used instead of two 99213 visits. Therefore, the post service time was reduced by 8 minutes to a total of 153 minutes. The physician time and number of visits was

also supported by building block analysis comparing the new code to the reference service code. **The RUC recommends a work relative value for CPT code 34805 of 21.88.**

Practice Expense

The RUC accepted the practice expense inputs after revising the post-op visits, which are based on the standard 090-day global practice expense inputs.

Upper Extremity Bypass Graft (Tab 11)

Gary Seabrook, MD, and Robert Zwolak, MD of the American Association for Vascular Surgery

The CPT Editorial Panel created four new codes (35510, 35512, 35522, and 35525) to describe bypass graft of four anatomical sites of the upper extremities, and while these procedures are so rare that they have been previously coded using the unlisted procedure code, these procedures are established and new codes are warranted. The new codes involve bypass procedures that are long and complex that extend from the common carotid, subclavian, axillary or the proximal brachial arteries to the more distal brachial artery. All new codes use vein conduit.

For all four codes, the specialty society received survey data from 32 vascular surgeons.

CPT Code 35510 and 35512

The survey respondents determined a median relative value for new CPT code 35510, *Bypass graft, with vein; carotid-brachial*, to be 23.00 RVWs based on time and intensity comparisons. Respondents selected CPT code 35511, *Bypass graft, with vein; subclavian-subclavian (RVU=21.20)*, as a reference service to the procedure. Based on the results of this comparison, CPT code 35510 has 28 more minutes of pre-service time, 30 more minutes of intra-service time, and 15 more minutes of post-service time. In comparing other bypass codes, the RUC questioned the inconsistency between existing bypass codes and the new code for hospital and post-operative care visits. The specialty agreed with the RUC that the hospital visits for new code 35510 should also include one 99231 service, and the post service visits for codes 35510 are appropriate as suggested, as the incision is large. The additional hospital visit will create consistency among all of the new bypass graft codes. The accepted time for code 35510 were 103 minutes of pre-service time, 180 minutes of intra-service times, and 191 minutes post service time. Intra-service intensity, technical skill required, and risk of complications, morbidity and/or mortality are substantially higher for the new service than the reference service. Clinically, the new and reference service codes are similar, however, with dissection of the carotid artery the incremental intensity increases because of the risk of stroke. The RUC agreed that the intra-service intensity is reasonable when compared to range of intensities (0.077 – 0.100) for the family of bypass codes that are performed with vein conduit. Based on the

survey results for time, and intensity comparisons, the RUC accepted the specialty society's recommendation.

The RUC recommends a work relative value of 23.00 units for CPT code 35510.

The survey respondents determined a median relative value for new CPT code 35512, *Bypass graft, with vein; subclavian-brachial*, to be 22.50 based on time and intensity comparisons. Respondents selected CPT code 35511, *Bypass graft, with vein; subclavian-subclavian (RVU=21.20)*, as a reference service to the procedure. Based on the results of this comparison, CPT code 35512 has 28 more minutes of pre-service time, 30 more minutes of intra-service time, and 32 more minutes of post-service time. The specialty agreed with the RUC that the hospital visits should also include one 99231 service, and the post service visits for code 35512 are appropriate as suggested, as the incision is large. The intensity and complexity for new code 35512 is nearly identical to the intensity of the reference service code. The most complex portion of the procedure involves dissection of the subclavian artery above the clavicle in the midst of multiple nerves and veins. In addition, the location is closer to the pleura, and pneumothorax is a potential risk. The RUC agreed with the specialty that the recommended RVU of 22.50 is justified based on the substantial extra time with essentially equal intensity.

The RUC recommends a work relative value of 22.50 for CPT code 35512.

CPT code 35522

The specialty society agreed with survey respondents that the median RVW of 21.76 appropriately reflected the time and intensity of the new service described by code 35522, *Bypass graft, with vein; axillary-brachial*, based on comparisons to the reference service code and building block analysis. The respondents selected CPT code 35518, *Bypass graft, with vein; axillary-axillary, (RVU= 21.20)*, as the reference service to this procedure. The survey respondents found that the new service has 28 minutes more pre-service time, 40 minutes more intra-service time, and 15 minutes more post-service time than the reference service. The intensity and complexity of the reference service code was nearly identical to the new code. The most complex and intense portion of the operation involves dissection of the axillary artery under the clavicle in the midst of multiple important nerves and large veins. This area is also adjacent to the pleura, and pneumothorax is an additional potential risk. Based on the extractive and the nearly equal intensity, the RUC agreed with the specialty societies recommendation of 21.76 RVWs.

The RUC recommends a work relative value of 21.76 for CPT code 35522.

CPT code 35525

The specialty society agreed with the survey respondents that the median RVW of 20.63 reflected the time and intensity of the service described by new code 35525, *Bypass graft, with vein; brachial-brachial*. Respondents selected reference service code 35518, *Bypass graft, with vein; axillary-axillary*, (RVU= 21.20), as the reference service to the procedures. The respondents indicated that the new service has 25 minutes more pre-service time, 10 minutes more intra-service time, but 47 minutes less post-service time than the reference service. The intensity and complexity values in comparison to the new code are nearly identical. The recommended RVW of 20.63 is less than the work RVU for CPT code 35518 (work RVU=21.21). With more intra-service time, and nearly identical total time and intensity, the RUC questioned how the new code was less than the reference code recommended work RVU. After discussion, the RUC understood that the possibility of nerve damage may be more likely in the case of the axillary-axillary bypass procedure, therefore a lower RVU may be justified. Therefore, the RUC agreed with the specialty society recommendation. **The RUC recommends a work relative value of 20.63 for CPT code 35525.**

The RUC clarified that venous duplex mapping is separately reported, as it is typically performed one week in advance.

Practice Expense

The RUC accepted the practice expense inputs after revising the post-operative visits, which are based on the standard 090-day global practice expense inputs.

Re-implantation of Visceral Artery (Tab 12)

Gary Seabrook, MD, and Robert Zwolak, MD of the American Association for Vascular Surgery Facilitation Committee #2

The CPT Editorial Panel created one new code, 35697 *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery*(List separately in addition to code for primary procedure), to describe a rare number of procedures, e.g. re-implantation of the inferior mesenteric artery to prevent ischemic gangrene of the left colon during open aortic reconstruction.

A relative work value survey median of 4.25 was collected from 33 vascular surgeons, who indicated an intra-service time for the add-one code of 30 minutes. After review of the survey data, the RUC questioned the varied response from survey respondents, and also the fact that the IWPOT did not match with the recommended work RVU. In an attempt to provide stronger rationale for the recommended RVU, two competing methodologies emerged

from the discussion, one based on IWPUT and the other based on selecting the 25th percentile RVU. The RUC discussed in detail these two alternatives, and determined that the appropriate RVU should be based on survey data, which takes precedence over the IWPUT. After reviewing the procedure with the specialty, the committee agreed that the 25th percentile value of 3.00 better reflected the actual work related to the procedure. As the utilization for these codes is only one percent of the total volume of six base codes (35102, 35081, 35646, 35647, 35082, 35103), **the RUC recommends that CMS determine the work neutrality based on the percentage of utilization for these six base codes.** The RUC understands that this will have minimal or no effect of these six existing codes.

The RUC recommends a relative work value of 3.00 for CPT code 35697.

Practice Expense

This is an add-on code and no additional practice expense inputs are necessary.

Implantation of Central Venous Access Devices (Tab 13)

Bibb Allen, Jr., MD, American College of Radiology, American Society of Anesthesiologists, Charles Mabry, MD, American College of Surgeons, Zachary Rattner, MD, and Society of Interventional Radiology, Samuel Smith, MD, FACS, American Pediatric Surgical Association

History

In the second, Five-Year Review of the RBRVS, CPT code 36489 *Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous over age 2* was increased from 1.22 to 2.50 work relative value units, as a rank order anomaly existed between this service and CPT code 36010 *Introduction of catheter, superior or inferior vena cava* (work RVU = 2.43). In addition, a number of other services in the family were identified as potentially mis-valued. CPT codes 36533, 36534, and 36535, which described the insertion, revision, and removal of implantable venous access device, and/or subcutaneous reservoir were considered by the RUC, but the RUC noted that the descriptor stated “and/or subcutaneous reservoir.” The RUC stated that there are multiple venous access capabilities for varying disease processes which require varying degrees of work for different venous access devices. Therefore, the RUC agreed to refer this issue to CPT to create specific codes that are more descriptive of the actual service being performed.

The CPT Editorial Panel created a Central Venous Access Procedures Workgroup, who worked on this issue for nearly two years. The results of their efforts is a new section in CPT for Central Venous Access Procedures that describes these services in five categories:

1. Insertion (placement of catheter through a newly established venous access)
2. Repair (fixing device without replacement of either catheter or port/pump, other than pharmacologic or mechanical correction of intracatheter or pericatheter occlusion (see 36535 or 36536 for those procedures))
3. Partial replacement of only the catheter component associated with a port/pump device, but not entire device.
4. Complete replacement of entire device via same venous access site (complete exchange).
5. Removal of entire device.

Work Relative Value Recommendations

Five specialties participated in a survey of the physician work involved in this family of services, including general surgery, radiology, interventional radiology, pediatric surgery, and anesthesiology. The specialties then met to review the survey results and develop consensus recommendations. At the April RUC meeting, these specialties met with a pre-facilitation committee on several occasions to further refine their recommendations to the RUC. The specialties did note that the surveys were problematic. For example, there was not a difference in work indicated for pediatric patients. The specialty believes this is due to few pediatric surgeons participating in the survey. The RUC agreed that a difference should be reflected in the final RUC recommendations. The RUC reviewed alternative ways to value codes, such as the use of IWPUT, and steps to ensure appropriate rank order and relativity within the family of services.

In developing the recommendations, the specialties arranged the CPT codes into families of similar services, based upon the original code which was replaced. An anchor code was selected based upon frequency, or the base code, or upon a direct cross-walk. The specialties reviewed the IWPUT of the survey results and used this IWPUT as a general guide to each family of codes. The IWPUT was used as a check of the value determined by the survey and of the relationships within a family and between types of codes (eg, pediatric versus adult codes).

The RUC agreed with the specialties' presentation, as the pre-facilitation committee had significant input into the final work relative value recommendations. A rationale for the work relative value for each individual CPT code is attached. The following attachments are appended to the recommendation:

Attachment A: Survey sample and response distribution for each of the procedure codes

Attachment B: Comparison data for reference and surveyed procedure codes

Attachment C: Rationale for work relative value recommendations for individual CPT codes

Attachment D: Medicare utilization and new frequency estimated percentages. The RUC reviewed this document and understands that the relative value recommendations for this new family of services are work neutral to the old family of services.

Practice Expense Inputs

The RUC reviewed the practice expense inputs and had numerous questions regarding the pre-service time. The specialties then prepared the attached spreadsheet labeled “pre-time rationale.xls” that identifies for each code the following: whether or not the service requires conscious sedation; whether it is performed on the same date as an E/M service; and a description of the typical patient scenario. The specialty also provided the specific break down of pre-service clinical staff time. The RUC reviewed this allocation of time and understands that it is consistent with the gastrointestinal endoscopic and colon and rectal surgery services that have been refined through the PEAC. The PEAC/RUC have granted time closer to 30 minutes pre-time for services that involve stents, etc. The CVA codes that are assigned 26 minutes pre-time for the facility setting involve services that require lines, ports, and pumps.

The RUC also revised staff, supplies, and equipment for the radiology add-on codes, 75998 (L27) and 76937 (L28). These codes, however, will be included in the zero work pool. A letter is attached that explains that CPT code 76003 should be utilized as a crosswalk for code 75998 (L27) and CPT code 76942 should be utilized as a cross-walk for code 76937 (L28). However, it should be noted that the clinical staff time for new code 76937 is only 25% of the staff time required for code 76942. The RUC recommends that CMS adjust the cross-walked practice expense relative value accordingly.

The revised practice expense recommendations and supporting materials are attached to the recommendation.

Distal Revascularization and Interval Ligation (Tab 14)

Gary Seabrook, MD, and Robert Zwolak, MD of the American Association for Vascular Surgery

After the review of sufficient supportive clinical data, demonstrating both efficacy and safety, the CPT Editorial Panel added one new code to describe the open surgical procedure distal revascularization and interval ligation for

the treatment of steal syndrome that occurs in a small proportion of patients who undergo upper extremity hemodialysis access operations.

The new CPT code 36838, *Distal revascularization and interval ligation (DRIL) upper extremity hemodialysis access (steal syndrome)*, (Do not report 36832 in conjunction with 35512, 35522, 36832, 37607, 37618), is a unique operation that is performed on the arm to treat hemodynamic steal syndrome. The specialty society surveyed 31 vascular surgeons, who indicated that the median work value should be 20.00 RVUs. For the new code, respondents indicated a pre-service time of 100 minutes, and intra-service time of 150 minutes, and a post-service time of 161 minutes. The survey respondents selected CPT code 35556, *Bypass graft with vein, femoral-popliteal*, (RVU= 21.76), as a reference service to the new code. However, the selected reference service has a longer intra-service time (200 minutes) and longer post-service times (330 minutes), and is performed on the lower extremity, while the new service with lower intra-service and post-service times, has much higher intensity/complexity values in mental effort and judgment, as well as psychological stress factors, since the patient's hand is at risk. Therefore, the specialty society recommends a work relative value of 20.63, which is equal to the work for new CPT code 35525, *Bypass graft, with vein; brachial-brachial*. The RUC questioned whether the procedure was more difficult than that for a bypass procedure of the vein, brachial-brachial, and the specialty indicated that using a building block analysis the two codes were compared and the time and visits for CPT code 35525 and 36838, were similar in that they both had intensities in the upper range. Given the time and intensity comparisons to an alternate reference code 35525, the RUC determined that specialty societies recommendation was reasonable and accepted the value.

The RUC recommends a work relative value of 20.63 for CPT code 36838.

Practice Expense

The RUC accepted the standard 60 minutes for these 90-day facility only procedures. For work related to facility discharge, 12 minutes of clinical staff time was accepted. Standard E/M post-op visit time for clinical staff has been applied for each office visit. Standard supplies and equipment necessary to perform the procedures and for the post-op visit were requested. The practice expense input recommendations are attached.

Varicose Vein Stab Phlebectomy (Tab 15)

Gary Seabrook, MD, and Robert Zwolak, MD of the American Association for Vascular Surgery

The CPT Editorial Panel created two new codes and revised one existing code to describe new open surgical procedures to treat symptomatic varicose veins.

CPT code 37765 and 37766

The specialty society surveyed 41 vascular surgeons for new CPT code 37765 with the following description, *Stab phlebectomy of varicose veins, one extremity; up to 20 stab incisions*, and determined a median RVW of 11.00. During the review of the new codes, the specialty society became aware that the recommended work RVUs may be too high. Therefore, the specialty society provided a new recommendation based on IWPUT and the building block approach. Survey respondents indicated an intra-service time of 60 minutes, a pre-service time of 58 minutes, and a post-service time of 81 minutes. The presenters analyzed intensity of the vein excision codes 37700, 37720, 37730, 37780, and 37785 which yielded a range of intensities between 0.063 to 0.070, and determined that the midpoint of 0.066 could be used as an accurate comparison to the new code. This intensity of 0.66 was multiplied by the surveyed intra-service time of 60 minutes. The standard building block method was then used to revised the recommended RVU to 7.35, which placed the code in proper rank order to the vein excision codes. The typical patient is 10-15 incisions, the original CPT proposal recommended a code for up to 15 incision, a code for 16-30 incisions, and more than 30 incisions. The RUC asked the specialty society to work with the CPT Editorial Panel to clarify the wording for these codes by modifying the description to indicate 10-20 incisions. The RUC also requested the addition of a parenthetical note to state for less than 10 incisions, use the unlisted code 37799. The CPT Editorial Panel has modified the nomenclature for CPT 2004 to read, *Stab phlebectomy of varicose veins, one extremity; 10 – 20 stab incisions (For less than 10 use 37999) (For more than 20 incisions, use 37766)*.

Similarly, for CPT code 37766, *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions*, the presenters used the 0.066 midpoint intensity and building block approach to revise the work relative value determined by the survey respondents. The survey respondents indicated a pre-service time of 58 minutes, an intra-service time of 90 minutes, and a post-service time of 81 minutes. The intra-service time of 90 minutes was multiplied by the midpoint intensity for vein excision codes of 0.066. A building block method was then used to include the pre- and post-service times. This process resulted in a final RVU of 9.30, a decrease from the originally proposed RVU of 11.00. The RUC agreed that the new values better reflected work for the typical patient, requiring between 10-15 incisions and also placed the code in proper rank order, in comparison to the vein excision codes.

The RUC recommends a relative work value of 7.35 for CPT code 37765 and a relative work value of 9.30 for CPT code 37766.

CPT code 37785

The specialty society is in the process of submitting a code change proposal request to CPT for existing code 37785 that will address various issues,

including the “recurrent” issue and will survey the code after the nomenclature has been revised.

Practice Expense

The practice expense inputs were accepted as submitted, and are attached to this recommendation.

Bone Marrow/Stem Cell Services (Tab 16)

Samuel Silver, MD, PhD, American Society of Hematology

CPT codes 38207 – 38215, which describe a series of bone marrow and stem cell harvesting services, were created for *CPT 2003* and will be slightly modified in *CPT 2004*. The RUC had previously reviewed this series of services and had developed interim work relative value recommendations. The RUC had requested that the specialty re-survey these codes after the CPT Editorial revised the nomenclature for the codes. In the December 31, 2002 *Final Rule*, CMS announced that it had decided that relative values should not be assigned to these services.

At the April 2003 RUC meeting, the specialty informed the RUC that they were currently discussing this issue with CMS and hoped to resolve the issue regarding the assignment of work relative values to these services in the near future. Upon resolution of this issue with CMS, the specialty will conduct a survey and present relative value recommendations to the RUC. The specialty requested that the RUC’s earlier “interim” recommendations remain in effect until the specialty has the opportunity to re-survey these codes. The RUC accepted this request and AMA RUC staff will monitor the specialties discussions with CMS to determine an appropriate time to re-schedule this issue on the RUC’s agenda.

Esophagogastroduodenoscopy (EGD) with Ultrasound Exam (EUS) (Tab 17)

Maurits Wiersema, MD, American Society of Gastrointestinal Endoscopy and Joel Brill, MD, American Gastroenterological Association

The CPT Editorial Panel created two new codes and revised two existing codes to clarify the differences in endoscopic ultrasound examinations. Code 43237 *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus* represents esophagogastroduodenoscopy with the endoscopic ultrasound examination limited to the esophagus. Code 43238 *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)* represents esophagogastroduodenoscopy (EGD) with the endoscopic ultrasound

examination (EUS) and a fine needle aspiration/biopsy limited to the esophagus. The existing codes 43242 and 43259 were revised to clarify that they involve an EUS examination of the complete upper GI tract, not just one confined solely to the esophagus or solely to the stomach. The specialty societies presented a family of esophagogastroduodenoscopy codes, however the initial recommendation omitted code 43259. During the presentation it appeared that the value for this code may change since CMS would revisit the valuation of code 43259 after the review of the two new EGD codes (43237 and 43238) at the April 2003 RUC meeting. The RUC felt that all the EGD codes needed to be examined at the same time and asked the specialty to revise its presentation. The following RUC recommendations are based on the revised presentation.

43237

This code represents a diagnostic EGD with the ultrasound examination limited to the esophagus. Although the survey data supported a higher value, the RUC felt that a value based on the survey data would not place the code in a proper rank order, and the following building block approach was used. The value assigned to a diagnostic EGD, code 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 2.39) was used a starting point for valuation. The RUC added the incremental work assigned to code 43231 *Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination* (work RVU = 3.19) and then subtracted the work RVU of code 43000 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 1.59), which results in a value of 1.60. This incremental work value represents the intra-service work only of EUS. Adding 1.60 and 2.39 results in a recommendation of 3.99 for code 43237. **The RUC recommends a work RVU of 3.99 for code 43237.**

43238

This code represents diagnostic EGD with the ultrasound examination and fine needle aspiration/ biopsy limited to the esophagus. The RUC did not use a building block approach for this code since it would have produced a rank order anomaly. Therefore this code was cross walked to other codes outside of the GI endoscopy procedures that involved similar time and complexity. In particular code 31641 *Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)* (work RVU = 5.03) had the same intra-service time of 70 minutes as 43238. Therefore the RUC agreed to crosswalk to value of 5.03 since this was reasonable comparison of physician work and placed the code in proper rank order. **The RUC recommends a work RVU of 5.03 for code 43238.**

43242

This code represents EGD with endoscopic ultrasound and fine needle aspiration (FNA)/biopsy. The editorial changes do not reflect any change in physician work. This code has been previously valued by the RUC at 7.31 work RVUs. The RUC verified the value of this service by comparing it to *52343 Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 7.20). **The RUC recommends a work RVU of 7.31 for code 43242.**

43259

This code represents EGD with endoscopic ultrasound. This code was assigned a value by CMS of 4.89 RVUs after the second five-year review although the RUC recommendation was for 8.59 work RVUs. The current valuation of 4.89 work RVUs presents rank order anomalies with other GI endoscopic procedures, including GI endoscopic ultrasound procedures. This code was compared to other GI endoscopy codes with similar complexity such as code 43260 *Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 5.96 and code 45385 *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU = 5.31). The RUC agreed that the complexity is similar to 45385, but slightly less and recommend an RVU of 5.20. It is anticipated that approximately 20% of procedures currently reported with 43259 will now be reported using 43237. The final work RVU recommendations take this into account so that the recommended values for the new codes are work neutral recommendations. **The RUC recommends a work RVU of 5.20 for code 43259.**

Practice Expense

The RUC approved the practice expense recommendations for 43237 and 43238 that were based on previously approved practice expense inputs for GI codes.

Living Donor Hepatectomies (Tab 18)

Michael Abecassis, MD, FACS, American Society of Transplant Surgeons, Charles Mabry, MD, FACS, American College of Surgeons

During the second five-year review, the RUC referred the donor hepatectomy issue to CPT for further consideration. As a result, the CPT Editorial Panel created three new codes to differentiate the live donor hepatectomy procedures. The live donor codes differ from the cadaver donor code in that only part of the liver is removed and this is significantly more difficult requiring additional skill. This procedure also has additional risks to a healthy volunteer donor, and is more comparable to the family of liver resection codes which are used as reference services (47120 -47136). The three new codes differ according to the amount of liver that is removed. Codes 47141 and 47142 share the same parenchymal transaction through Cantlie's line, the

major fissure of the liver and, therefore, are both associated with greater effort on the part of the surgeon with greater risk to the donor. Also, these two codes require a closer dissection to the bifurcation of the portal structures associated with greater risk of complications as this dissection is more difficult due to the anatomy of both the hepatic vein and biliary tree. The liver resection codes are anatomically similar but both pieces of the liver need to be preserved. This does not allow for hilar vascular control, which is typically performed in standard resections. Therefore, this predisposes the parenchymal transection to bleeding. The need to meticulously identify and preserve vascular and biliary structures that cross the interlobar fissure mandates the use of advanced technologies for the parenchymal transaction, to minimize both bleeding and injury to the biliary and vascular structures that may need to be reconstructed.

These considerations increase the time and complexity for the procedure as compared to standard liver resections and support a higher work RVU. The RUC reviewed these three codes as a group and agreed that in comparison the liver resection codes, the new codes require more work due to the differences in dissection and the need to preserve the liver for transplantation and also to minimize blood loss of the donor and to preserve the donor's liver. Also for 47141 and 47142 repeated fluoroscopic cholangiography is always used.

The RUC compared code 47140 *Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)*, to code 47125 *Hepatectomy, resection of liver; total left lobectomy* (work RVU = 49.19) and 47122 *Hepatectomy, resection of liver; trisegmentectomy* (work RVU = 55.13) and agreed that based on the survey results and description of the additional work required for a living donor resection, the 25th percentile work RVU of 55.00 placed the code in proper rank order. **The RUC recommends a work RVU of 55.00 for code 47140.**

The RUC compared code 47141 *Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total left lobectomy (segments II, III and IV)* to code 47125 *Hepatectomy, resection of liver; total left lobectomy* (work RVU = 49.19) and 47122 *Hepatectomy, resection of liver; trisegmentectomy* (work RVU = 55.13) and code 47135 *Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age* (work RVU = 81.51) and agreed that the median RVU of 67.50 was supported by the survey data. Given the differences in time and intensity, the recommended median RVU placed the codes in proper rank order among the reference codes. **The RUC recommends a work RVU of 67.50 for code 47141.**

The RUC compared code 471X3 *Donor hepatectomy, with preparation and maintenance of allograft, from living donor total right lobectomy (segments V, VI, VII and VIII)* to two reference codes, 47130 *Hepatectomy, resection of liver; total right lobectomy* (work RVU = 55.35) and code 47135 *Liver*

allograft transplantation; orthotopic, partial or whole, from cadaver or living donor, any age (work RVU = 81.51). The RUC compared the physician time and intensity ratings of the new code to the reference codes and based on the thorough explanation of the procedure, the RUC agreed that the median recommended RVU was supported by the survey data and placed the code in proper rank order. **The RUC recommends a work RVU of 75.00 for code 47142.**

Practice Expense

The RUC examined the practice expense recommendations in great detail especially the pre-service time. The presenters described four educational sessions, each requiring two hours of clinical staff time. The RUC discussed each of the four phases that occur prior to surgery and was unable to specifically identify which phase equates to a decision for surgery. Since clinical labor activities for practice expense purposes begin after the decision for surgery is made it is important to determine when the decision is made during the donor search period. The presenters stated that during the four phases preceding the operation, they are not able to separately bill for any of the visits that relate to the donor search and meeting with the potential donors.

The presenters initially explained that they interpreted the decision for surgery to begin once the call for donors is issued and therefore the clinical labor required for all four phases should be included as a practice expense. The recommendation was revised to include four hours of clinical staff time to include phases III and IV. The RUC disagreed and as an interim measure the RUC concluded that the decision for surgery occurs after the completion of phase III. The pre-service times were reduced to only include time that would begin after phase III. Therefore, the pre-service time should include the one hour of standard pre-service time plus the two hours of pre-service education during the phase IV information session. An additional 15 minutes for significant additional atypical coordination with multiple physicians, surgeons and two patients was assigned. Also, 30 minutes for additional atypical pre-service diagnostic and referral form completion was allocated for a total pre-service time of 285 minutes. The presenters described this phase IV session as consisting of the donor and their family and the recipient and their family meeting with the physician and staff for a thorough review of the operation and risks to the donor. Every effort is made to be certain that there is no coercion from anyone and that the donor completely understands the operation, postoperative recovery, and the risks they are taking. This session is generally scheduled for two hours. Given the uncertainty of when the decision for surgery is made during the four phases that occur before surgery, the RUC deferred to CMS and the presenters to make a final determination and adjust the pre-service times accordingly. The specialty society has provided the New York state guidelines used in donor searches and this information is attached to the recommendation.

Laparoscopic Colpopexy (Tab 19)

George Hill, MD, FACOG, Vicente Lucente, MD, FACOG, and Sandra Reed, MD, FACOG, American College of Obstetricians and Gynecologists, American Association of Gynecological Laparoscopists

CPT created a new code to specifically describe the laparoscopic approach to correct female pelvic support defects. This laparoscopic method is becoming more widespread due to the increasing laparoscopic surgical skills of physicians. The RUC compared the new code 57425 *Laparoscopy, surgical, colpopexy (suspension of vaginal apex)* to code 57280 *Colpopexy, abdominal approach* (work RVU = 15.04). The RUC agreed with the presenters that the new code is very similar to the reference code. The surveyed code requires more physical effort than the reference code but the reference code has an easier post-op management period. The presenters stated that these two factors balance each other out and result in the two codes being essentially the same procedure. The survey respondents ranked the laparoscopic code higher in each of the intensity/complexity measures. While it is generally the same procedure, there are elements of laparoscopic surgery that justify a slightly higher RVW value for the surveyed code in comparison to the reference code.

- Laparoscopic surgery does not have the reduced intensity during opening and closing, as do abdominal surgeries.
- Laparoscopic surgery requires the development of specialized skills .
- Laparoscopic surgery requires the physician to view their surgical environment using cameras and other technology

To ensure proper rank order, the RUC accepted the 25th percentile RVU of 15.75. In addition, the RUC agreed with the presenters proposal to reduce the pre-service time from the surveyed time of 85minutes to 60 minutes. Using this reduced pre-service time, which matched the reference service pre-service time, produced an IWPUT consistent with the reference service. **The RUC recommends a work RVU of 15.75 for code 57425.**

Practice Expense

The RUC accepted the standard packages for 90 day global procedures.

Intrauterine Fetal Surgical Procedures (Tab 20)

George Hill, MD, FACOG, American College of Obstetricians and Gynecologists

The RUC considered a request that this family of codes be carrier priced for 2004 since the presenters were unable to obtain sufficient survey data. The presenters will make recommendations to the RUC at the September, 2003 RUC meeting. **The RUC recommends that codes 59070, 59072, 59074, 59076, and 59897 be carrier priced for 2004.**

Limited Temporal Lobe Resection and Lobectomy (Tab 21)
Jeffrey Cozzens, MD American Association of Neurological Surgeons/Congress of Neurological Surgeons

The CPT Editorial Panel created the limited temporal resection and lobectomy without corticography codes to describe the recent developments which have allowed lobectomies to not involve electrocorticography. In addition, new codes and revisions to existing codes were developed to describe the latest techniques which have been developed for limited temporal lobe resection, functional hemispherectomy, and multiple subpial transactions.

61537

The RUC examined code 61537 *Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring; for lobectomy, temporal lobe, without electrocorticography during surgery*. It was determined by the RUC after reviewing reference code 61538 *Craniotomy with elevation of bone flap; for lobectomy, with electrocorticography during surgery, temporal lobe* (RVU = 26.81) that the intra-service time of the new code (intra-service time = 240 minutes) is higher than the intra-service time of the reference code (intra-service time 210 minutes). In addition, the intra-service period of the new code was deemed more intense than the reference code. This time and intensity difference between these two codes was reflected within the specialty society's survey which had a median RVW of 27.66. However, the RUC agreed with the specialty society that the 25th percentile RVW for 61537 is appropriate as it maintains the relativity to the reference code 61538. **Therefore, the RUC recommends a work relative value of 25.00 for 61537.**

61540

The RUC examined code 61540 *Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring; for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery*. It was determined by the RUC after reviewing reference code 61539 *Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, other than temporal lobe, partial or total* (RVU = 32.08) that the intra-service time of the new code (intra-service time = 300 minutes) is similar to the intra-service time of the reference code (intra-service time = 297 minutes). , the RUC agreed with the specialty society's survey median, 30.00 RVW as it correctly places the work value for 61540 between 61537 and 61539. The RUC noted that the IWPUT for 61537 and 61540 is also similar. **The RUC recommends a work relative value of 30.00 for 61540.**

61566

The RUC examined code 61566 *Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy*. Amygdalohippocampectomy is a fairly new procedure which is very low volume and is only performed at certain

epilepsy centers. Although the procedure is performed through a similar craniotomy, amygdalohippocampectomy involves a microsurgical approach and dissection of these tissues without injuring the lateral temporal lobe.

Amygdalohippocampectomy is a painstaking procedure which takes roughly two more hours than an amputation. Amygdalohippocampectomy is generally performed without electrocorticography since it is an anatomical resection. It was determined by the RUC after reviewing the intra-service time of the surveyed code (intra-service time = 240 minutes) that it is significantly more when compared to the intra-service time of the reference code 61538

Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe (intra-service time = 210) (work RVU = 26.81). In addition, 61566 is deemed more intense and requires more mental effort and judgment than the reference code. Therefore, the RUC agrees with the specialty society that the increased time and intensity required to perform this procedure support the specialty society's median value of their survey (RVU = 31.00). **The RUC recommends a work relative value of 31.00 for 61566.**

61567

The RUC examined code 61567 *Craniotomy with elevation of bone flap; for multiple subpial transections, with electrocorticography during surgery*. This procedure involves a large hemispherical craniotomy and extensive intraoperative electrocorticography. In comparison, the reference code 61536 *Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)* (RVU = 35.52) involves a similar craniotomy and resection of an epileptogenic focus defined by electrocorticography. 61567 involves dissection to disconnect the horizontal cortical connections and to preserve the vertical axons, thus limiting seizure spread without removing this "eloquent" brain. This must be performed without interrupting the blood supply to that cortex. As such, this is a more intense procedure which carries a higher risk of serious complications as compared to the reference code. Although the intra-service time of 61567 (intra-service time = 280 minutes) is less than the reference service code (intra-service time = 298), the intensity, as reflected also in its IWPUT of 0.091, is in keeping with the intensity of other high risk intracranial procedures. Therefore the RUC agreed with the specialty society that the median survey RVW of 35.50 is recommended for 61567. This recommendation is similar to the work value of the reference code and fairly balances the higher intensity intra-service component with the lower intra-service time. **The RUC recommends a work relative value of 35.50 for 61567.**

Practice Expense:

The practice expense inputs for 61537-61567 follow the PEAC accepted neurosurgery craniotomy procedure packages and the RUC approved "standard" neurosurgery post-operative incision care kit. **The practice expense**

recommendations presented by the specialty society were accepted by the RUC.

Deep Brain Stimulation (Tab 22)

Robert Florin, MD, American Society for Stereotactic and Functional Neurosurgery, Jeffrey Cozzens, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons Facilitation Committee #3

The CPT Editorial Panel has created the following four codes to accurately describe the work associated with deep brain stimulation (DBS) with and without the use of intra-operative microelectrode recording (MER).

61863

Code 61862 *Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray); with use of intraoperative microelectrode recording* (2003 MFS RVU = 19.34, 27.34 was a previous RUC recommendation) includes a mixture of cases that included MER along with cases that did not use MER. This code is being deleted and replaced by 61863 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array* and 61867 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array*. The specialty society convened a consensus committee to review the results of the surveys and to determine the appropriate work RVU recommendation. The consensus committee reviewing these codes estimated that the split between 61863 and 61867 will be approximately 40:60. Recommendations for 61863 and 61867 were created in tandem in an effort to: 1) maintain work neutrality; 2) approximate the survey data; and 3) allow for a work RVU spread between 61863 and 61867 to account for 160 minutes of additional intra-operative time.

To accomplish the first task, the specialty society's consensus panel reviewed the 2001 CMS utilization information on 61862. In the 2001 CMS utilization file there was 951 allowed claims for 61862. This number multiplied by 27.34 RVUs equals 26,000 RVUs (27.34 is the RUC approved RVU for 61862 and after reviewing the time/motion analysis, CMS also accepts that this value more closely approximated the work of 61862). After looking at the utilization information and the surveys, the consensus panel estimated that the split between 61863 and 61867 will be 40:60. Therefore, by using the 2001 CMS utilization information on 61862 (951 allowed claims), they

approximated the utilization of 61863 to be 380 claims and estimated the utilization of 61867 to be 571 claims. Then, the consensus panel, took the utilization data for 61862, 951 allowed claims, and multiplied this number by the 27.34 RVWs, the RUC accepted work RVU for this code, which resulted in a total of 26,000 RVUs. The specialty society determined that the total recommended RVUs for 61863 and 61867 should not exceed this total RVUs amount in order to maintain work neutrality.

To accomplish the second and third task, the consensus panel reviewed the survey results and wanted to approximate the 25th percentile of the recommended work RVU (25th percentile recommended work RVU = 18.50). However, the consensus panel felt that the 25th percentile recommended work RVU was slightly conservative and felt that a recommendation of 19.00 work RVU was a more appropriate value for 61863. Therefore, when the consensus panel multiplied the 19.00 recommended work RVU for 61863 by the estimated utilization of this code, 380 claims, it resulted in 7,220 total RVUs. This same process was done for 61867 with a recommended work RVU of 31.34, slightly less than the 75th percentile recommended work RVU. This process resulted in 17,895 total RVUs for 61867. When the total RVUs for both 61863 and 61867 were added it closely approximated the total RVUs for 61862; 25,115 and 26,000 respectively. These calculations are shown in the table below.

Code	Split	'01 Util.	RVUs	RVW
61863	40%	380	7,220	19.00
61867	60%	571	17,895	31.34
<i>61862</i>	<i>100%</i>	<i>951</i>	<i>26,000</i>	<i>27.34</i>

The RUC agreed with the specialty society’s rationale behind their work RVU recommendation for 61863. **Therefore, the RUC recommends a work relative value of 19.00 61863.**

61864

The RUC examined code 61864 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array.* It was determined by the RUC after reviewing the reference code 63076 *Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)* (Work RVU = 4.05) that the intra-service time of the surveyed code (intra-service time = 68 minutes) is more than the intra-service time of the reference code (intra-service time = 63 minutes). In addition, the RUC agreed that the intensity of the surveyed code exceeded the intensity of the reference code. Therefore, the RUC agreed with the specialty society that the increased time and intensity required to perform this procedure support the specialty society’s median value of their survey

(work RVU = 4.50) which is minimally higher than the relative work associated with the reference code (Work RVU = 4.05). **The RUC recommends a work relative value of 4.50 for 61864.**

61867

The RUC examined code 61867 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array*. The specialty society initially had requested the 75th percentile (33.00 RVUs) surveyed results for this long intense surgical procedure. The presenters provided an extensive description of the service, as well as a more detailed explanation of their survey results. The RUC understood that this procedure is quite lengthy with the use of intraoperative microelectrode recording. In addition, the physician work intensity was comparable to new CPT code 61863 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array* (Recommended work RVU = 19.00) which was adopted by the RUC. The RUC believed that the survey respondents may have been underestimating the true time and work involved in the procedure, as the median survey results were lower given the direct correlation between time and intensity of 61863 to 61867.

The RUC reasoned that since the intra service work of 61863 is quite similar to 61867 within the new family of codes, the intensity of 61863 multiplied by the total median time for 6816X3 of 300 minutes plus the pre-service and post service work components results in a more reasonable and appropriate relative work value of 31.34 for the 61867. This work valuation would keep the proper rank order for the family of codes and represent the true physician work. Calculations are listed below.

$$300 \text{ Minutes} \quad \times \quad 0.078 \quad = \quad 23.40$$

Intra-service time of 61867 IWPUT of 61863 Intra-Service-RVW of 61867

$$23.40 \text{ (Intra-Service RVW of 61867)} + 1.80 \text{ (Pre-Service RVW of 61867)} \\ + 6.14 \text{ (Post-Service RVW of 61867)} = 31.34 \text{ Recommended RVW}$$

Based on these assumptions, and the typical patient encounter, **the RUC recommends a relative work value of 31.34 for 61867.**

61868

The RUC examined 61868 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative*

microelectrode recording; each additional array. The RUC determined that 61868 is an add on code to 61867 and similarly was determined to correlate directly with the intra-service work per unit of time of 61864 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array;* (Recommended work RVU = 4.50) which was adopted by the RUC. 61864 is also an add on code, but without the use of intra operative microelectrode recording. Members of the RUC believed that the intra-service work per unit of time for 61864, 0.066, multiplied by the median time of 61868, 120 minutes, would provide the appropriate work relative value. Calculations are listed below.

$$0.066 \text{ (IWPUT of 61864)} \times 120 \text{ Minutes (Intra Service Time of 61868)} = 7.92$$

Recommended RVW for 61868

In addition, the committee believed this would keep the rank order of this new set of codes. **The RUC recommends a relative work value of 7.92 for 61868.**

Practice Expense

The direct practice expense inputs were cross-walked from previously PEAC approved inputs for the neurosurgery family of codes for twist drill/burr hole procedures and RUC approved “standard” neurosurgery post-operative incision care kit. The practice expense inputs were approved by the RUC.

Lumbar and Superior Hypogastric Plexus Injections and Destruction (Tab 23)

**James D. Grant, MD, American Society of Anesthesiologists, Eduardo M. Fraifeld, MD, American Academy of Pain Medicine
Facilitation Group #2**

CPT created three new codes and revised an existing code to describe superior hypogastric plexus blocks since they require a technique substantially different from other blocks, and existing nerve block codes do not accurately describe this service.

64449

The RUC examined survey data for code 64449, *Injection, anesthetic agent; lumbar plexus, posterior approach continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration*, in relation to other codes in the family. The presenters explained that the survey respondents underestimated the intra-service time, since this is not a widely performed procedure. To prevent creating a rank order anomaly, the RUC identified CPT code 64448, *Injection, anesthetic*

agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration, as a reference code for physician work. In comparison to code 64448 (intra-service time of 25 minutes), the new code should have similar intra-service time. Therefore, the RUC recommends intra-service time of 25 minutes. Also, the RUC determined that a work RVU of 3.0 would place the code in proper rank order relative to the family. The RUC also examined code 64483, *Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level* (000-day global period, work RVU = 1.90), to provide additional support for an RVU of 3.00 and used the following building block comparison:

64483	1.90 RVU
<u>99231x2=</u>	<u>1.28 RVU</u>
	3.18 RVU

The RUC felt that 64483 plus two hospital visits had similar physician work to 64449.

Also, the recommended value of 3.00 lies between the 25th percentile and median survey values. The RUC is aware that two post-operative hospital visits identified through the survey are lower than the three post-operative visits that are included in the family of similar codes, yet the committee was not comfortable changing survey data. **The RUC recommends a work RVU of 3.00 for CPT code 64449 and 25 minutes of intra-service time.**

64517

The RUC reviewed code 64517 *Injection, anesthetic agent; superior hypogastric plexus* which is typically used in cancer patients for pain relief. In comparison to the reference codes the RUC concluded that the higher intensity measure supported a RVU greater than the reference services 64520 *Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)* (work RVU = 1.35) and 64530 *Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring* (work RVU= 1.58) and supported the median RVU of 2.20. The main differences among this code and the reference services in the intra-service intensity and complexity due to the difficulty in positioning and administering the block due to the anatomical area where this is performed. **The RUC recommends a work RVU of 2.20 for CPT code 64517.**

64681

The RUC reviewed the survey results, and agreed that the respondents appropriately rated the new service as more intense and complex and as requiring more pre- and post-service time compared to the reference services 64622 *Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level* (work RVU, 3.00) and 64680 *Destruction by neurolytic*

agent, celiac plexus, with or without radiologic monitoring (work RVU, 2.62). Additionally, a review of the RVUs of other injections listed in the reference service list illustrates that the recommended work RVU correctly rank orders the new code. A neurolytic trigeminal nerve block (CPT 64600) has 3.45 work RVUs. These are much simpler than a neurolytic hypogastric plexus block. In addition, a continuous brachial plexus block (CPT 64416) - a nerve block with a 10 day global period - has 3.50 work RVUs. A trigeminal nerve destruction of foramen ovale (CPT 64610) is valued at 7.16 RVUs. This code is similar to 64517 except that instead of injecting an anesthetic agent, this code involves a neurolytic agent. Typically, the patient is in the hospital and the anesthesiologist performs the procedure and also performs two follow-up hospital visits, but does not have any discharge day management work. This procedure can also be performed in the office, but most of these procedures are performed in the hospital setting in large cancer centers. The RUC concluded that the survey data supported the median RVU of 3.55. **The RUC recommends a work RVU of 3.55 for CPT code 64681.**

Practice Expense

The RUC determined that the standard pre-service times are applicable, however for 64449 and 64681, zero pre-service time in the facility setting was assigned since the patient is typically an inpatient and the hospital staff perform the pre-service work, not the physician's office staff. Also, the assist physician time was assigned at 100% of physician intra-service time. For code 64681, 2 office visits are assigned to the non-facility setting since when it is performed in this setting there are 2 office visits instead of the 2 hospital visits.

Upper Eyelid Load Implantation (Tab 24)

Neal Freeman, MD, Stephen Kamenetzky, MD, American Academy of Ophthalmology

A new CPT Code 67912 *Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)* was created to describe this procedure performed for corneal protection in cases of facial paralysis. This service has been performed for a number of years, however it has never been adequately described in CPT.

The RUC considered the survey results from nearly 30 ophthalmologists, with a survey median of 5.68. The specialty argued that the survey median did not adequately reflect the work of this service and presented a work relative value recommendation of 6.75, utilizing CPT code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work rvu = 6.26) as a reference service. Although the RUC agreed that the work of code 67912 was similar to 67904, the committee did not agree that it was more work. The RUC specifically did not agree with the inclusion of pre-visit, to determine the size of the weight, in the global period. This visit would typically be convened several days prior to the surgery, and therefore, it would

not be appropriate to include it in the work of the service. This visit would be reported separately. Accordingly, the pre-service evaluation time was reduced from 30 minutes to 15 minutes. The RUC also determined that the post-operative visits would be more appropriate at two 99213 and one 99212, rather than three 99213 visits. The effect of removing this work from the specialty's recommendation resulted in a work relative value comparable to the survey median. **The RUC recommends a work rvu of 5.68 for CPT code 67912.**

Practice Expense

The RUC reviewed the specialty's recommended direct practice expense inputs and verified that a medium surgical instrument package was warranted and added the standard cleaning supply package. The post-operative visits were modified to be consistent with the work relative value information. The RUC agreed that the one-on-one clinical staff time with the physician intra-service time was appropriate. The RUC understands that CMS will be reviewing the issue of expensive disposable supply items to determine if these supplies should remain in the procedure code or be paid via a separate HCPCS Level II code. The specialty indicated that the gold weight is typically used. However, for patients with a gold allergy, a substitute may be utilized. The recommended direct practice expense inputs will be attached to the recommendation.

Corneal Pachymetry Echography (Tab 25)

Ruth Williams, MD, Stephen Kamenetzky, MD, American Academy of Ophthalmology

The CPT Editorial Panel created a new code 76514 *Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)* to describe the measurement of corneal thickness. This service may be performed for patients who are candidates for corneal transplantation, as well as patients with glaucoma. Peer-reviewed literature has recently supported the importance of measuring corneal thickness in glaucoma patients. The incidence of glaucoma in the general population is 1 to 2 percent. The specialty indicated that most glaucoma patients may expect to receive this service once, while those with corneal disease may have the measurement completed on more than one occasion. The specialty also indicated that the utilization of these services will be higher in the first year or two of the code's release, as there will be a general catch up in measuring all glaucoma patients. After this initial period, it is expected that the test will only be performed on newly diagnosed glaucoma patients.

A survey of more than 30 ophthalmologists indicated that this service is similar in work to CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report* (work rvu = 0.50). However, the specialty determined that this service was more comparable to 76076 *Dual energy x-ray absorptiometry (DEXA) bone density study, one or more sites;*

appendicular skeleton (peripheral) (eg, radius, wrist, heel) (work rvu = 0.22); 71010 Radiologic examination, chest; single view, frontal (work rvu = 0.18); 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report (work rvu = 0.17); or 99211 Established patient office visit, level one (work rvu = 0.17).

The RUC reviewed the activities performed by the technician versus the physician. The specialty indicated that in some practices the physician will actually perform the measurement, while in others a technician would perform the measurement and the physician would then interpret the findings. The specialty stated that “the applanation of the central cornea could be done by a technician but typically will be performed by a physician. If the readings are taken by the technician rather than the physician, the physician still must establish the validity and import of the findings. The physician must address the following issues: If the corneal readings are thin, does the increased “true” pressure constitute a risk to the patient? If the difference in the applanation and corrected pressure using pachymetry significant enough to change the observation or management of the patient?” The RUC concurred that a small amount of physician work is appropriate as this test may modify another test and physician interpretation is necessary. The specialty also indicated that the medical record will include a written note from the physician, which includes the thickness and the impact on measurements of the intraocular pressure (IOP). An example of this note is attached to this recommendation.

The RUC also requested that the CPT Editorial Panel clarify that this code should be reported for either unilateral or bilateral measurements. The CPT Editorial Panel has modified the nomenclature to provide this clarification.

Practice Expense

The RUC clarified that this service is typically provided on the same date as an eye exam code or evaluation and management service. Therefore, there are minimal practice expense inputs associated with this service. Either the equipment must be moved into the patient or the patient is moved to the equipment. The RUC, therefore, thought the total clinical staff time of 5 minutes was reasonable. There are no medical supplies associated with this service. The only equipment is the ultrasonic pachymeter.

Intraoperative MRI (Tab 26)

Robert Florin, MD, American Society for Stereotactic and Functional Neurosurgery, Jeffrey Cozzens, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons Facilitation Committee #3

The CPT Editorial Panel created three new codes to describe new procedures and new technology (use of MRI during an operation to evaluate tumor in the brain during resection) which plays an increasingly important role in the treatment of patients with intracranial lesions, including neoplasm and skull base tumors. The existing MRI codes 70551, 70552 and 70553 describe the “radiologic supervision and interpretation” of the brain and do not reflect the

intra-operative time and effort involved in repeated image acquisition in real-time under stereotactic guidance and the intra-operative interpretation of the images which occurs sequentially throughout these new procedures.

70557

The RUC examined code 70557 *Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material*. The RUC began by discussing the survey data acquired by the specialty society due to the small number of surveys and the wide variation of times reported. Therefore, the RUC began to review the work RVU interval between the reference code 70551 *Magnetic resonance (eg proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)* (Work RVU = 1.48) and 70552 *Magnetic resonance (eg proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences*; (Work RVU = 1.78).

$$\begin{array}{r} \text{Work RVU of 70552} \\ (1.78) \end{array} - \begin{array}{r} \text{Work RVU of 70551} \\ (1.48) \end{array} = \begin{array}{r} \text{Interval} \\ (0.30) \end{array}$$

The RUC felt that this interval could appropriately be applied between 70557 and 70558 *Magnetic resonance (eg Proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)*. The RUC had accepted a work RVU recommendation of 3.20 for this code.

$$\begin{array}{r} \text{Work RVU of 70558} \\ (3.20) \end{array} - \begin{array}{r} \text{Interval} \\ (0.30) \end{array} = \begin{array}{r} \text{Work RVU of 70557} \\ (2.90) \end{array}$$

The RUC agrees that this rationale is appropriate and recommends a relative work RVU of 2.90 for CPT code 70557.

70558

The RUC examined code 70558 *Magnetic resonance (eg Proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)*. After reviewing the reference code 70552 *Magnetic resonance imaging; brain (including brain stem); with contrast material* (Work RVU = 1.78), the RUC determined that the reference code has a Harvard total time of 33 minutes as compared to the surveyed code with a total time of 195 minutes. In addition, the surveyed code was considered to be significantly more intense than 70552. However, the specialty society felt that because this reference code was selected by only twenty-five percent of the respondents that this data should further be examined by an expert consensus panel. The panel determined that 76394 *Magnetic resonance guidance for, and monitoring of tissue ablation* (Work RVU = 4.25) is an appropriate reference service. The RUC recognized that the median intra-service time obtained in the surveys for 70558 is 120 minutes and is 73% of the intra-

service time for 76394 (intra-service time = 165 minutes). Seventy-three percent of the physician work value of 76394 is approximately 3.2 RVUs. **Therefore, the RUC recommends a work RVU of 3.2 for 70558.**

70559

The RUC examined code 70559 *Magnetic resonance (eg Proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material, followed by contrast material(s) and further sequences*. After reviewing the reference code 70553 *Magnetic resonance imaging; brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (Work RVU = 2.36), the RUC determined that the reference code has a Harvard total time of 43 minutes as compared to the surveyed code with a total time of 195 minutes. In addition, the surveyed code was considered to be significantly more intense than 70553. However, the specialty society felt that because this reference code was selected by only twenty-five percent of the respondents that this data should further be examined by an expert consensus panel. The panel determined that 76394 *Magnetic resonance guidance for, and monitoring of tissue ablation* (Work RVU = 4.25) is an appropriate reference service. The RUC recognized that the median intra-service time obtained in the surveys for 70559 is 120 minutes and is 73% of the intra-service time for 76394 (intra-service time = 165 minutes). Seventy-three percent of the physician work value of 76394 is approximately 3.2 RVUs. In addition, the specialty society's survey results indicated no difference in intra-service time between the 70559 and 70558 and therefore the RUC felt that establishing the same physician work value for both seemed appropriate. **Therefore to account for the survey results and the results of the consensus panel, the RUC recommends a work RVU of 3.2 for 70558.**

Practice Expense

There are no practice expense inputs recommended for these codes.

Multiple Day Nuclear Medicine Whole Body Spect Imaging (Tab 27)

Bibb Allen, Jr., MD, American College of Radiology, Michael A. Wilson, MD, and Kenneth A. McKusick, MD, Society of Nuclear Medicine

Two existing codes were modified and one new code was created to account for the additional physician work and practice expenses when multiple day studies are required to complete nuclear medicine whole body or SPECT tumor imaging studies. Imaging for specific tumors with recently introduced radiopharmaceuticals, increasingly require multiple day studies. In addition, whole body imaging for pretreatment planning prior to radiopharmaceutical therapy must be performed on two or more days.

The RUC and the specialty society recommended that the existing codes have no change in their current physician work values. These two codes were merely modified within CPT to distinguish between imaging during one day

and for multiple days. The RUC reviewed codes 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86) and 78806 *Radiopharmaceutical localization of inflammatory process; whole body* (Work RVU = 0.86) in relation to revised code 78802 *Radiopharmaceutical localization of tumor or distribution or radiopharmaceutical agent(s); limited area*. In addition, the RUC reviewed the survey results of 78802 and agreed with the specialty society that the current relative value of 0.86 was still appropriate. **The RUC agreed with the rank order between the family of codes and recommends no change in the work relative values for CPT codes 78800 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area* (Work RVU = 0.66) and 78802 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging* (Work RVU = 0.86)**

New code 78804 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging* was reviewed by the RUC for its rank order as well as its survey results. The survey results indicated a median RVU of 1.53, however the specialty believed that in order to maintain accurate rank order, this new code should be valued closer to the survey's 25th percentile results. In relation to the specialty's key reference service 78806, as well as 78800 and 78802, the RUC accepted the specialty society's recommendations. **The RUC recommends a work relative value of 1.07 for CPT code 78804.**

Practice Expense

The RUC reviewed the in office practice expense recommendations for CPT codes 78802 and 78804. The specialty explained that the direct practice expense inputs for these codes were crosswalked from code 78306 *Radiopharmaceutical localization of inflammatory process; whole body*, and should be placed into the non-physician work pool. These services were explained by the presenters as typically performed in the non-facility setting and there would not be facility practice expense inputs for these codes. The RUC believed that the non-facility inputs were typical for the services provided, and accepted the data without modification.

Radiolabeled Monoclonal Antibody Infusion (Tab 28)

Bibb Allen, Jr., MD, American College of Radiology, Michael A. Wilson, MD, and Kenneth A. McKusick, MD, Society of Nuclear Medicine

Two existing codes were modified and one new code was created to account for a new procedure which describes a systemic treatment by infusion of a radiolabeled monoclonal antibody. The radiopharmaceutical (such as Sr89) is administered as an intravenous injection for which there is no expected immune reaction. The new procedure requires an infusion (not an intravenous injection) over an extended period, of a murine antibody to which there may be an allergic reaction. This procedure is not limited to nonthyroid,

nonhematologic tumors, polycythemia and chronic leukemia, and the treatment entails one infusion injection.

The RUC and the specialty society recommended that the existing codes have no change in their current physician work values. These two codes were clarified within CPT to indicate the radiopharmaceutical therapy treatment through intravenous injection. The RUC recommends no change in the work relative values for CPT codes 79100 *Radiopharmaceutical therapy, polycythemia vera, chronic leukemia, each treatment by intravenous injection* (Work RVU = 1.32) and 79400 *Radiopharmaceutical therapy, nonthyroid, nonhematologic by intravenous injection* (Work RVU = 1.96)

New code 79403 *Radiopharmaceutical therapy by, radiolabeled monoclonal antibody by intravenous infusion* was reviewed by the RUC for its rank order and its survey results. The RUC reviewed the specialty society's key reference code 79030 *Radiopharmaceutical ablation of gland for thyroid carcinoma* (Work RVU = 2.10), and the revisions of codes 79100 and 79400 in relation to the new code, and believed that the specialty society's median survey results provided the correct rank order between the two services. In addition, the RUC understood that an E/M code could not be billed in conjunction with 79403. The RUC thought the survey results reflected the physician work involved for this service, and believes this new service would have proper rank order within the family of codes with a relative work value of 2.25. **The RUC recommends a work relative value of 2.25 for CPT code 79403.**

Practice Expense

The RUC reviewed in-office practice expense recommendations for CPT code 79403 and the RUC believed that they were typical for the services provided. The RUC accepted the practice expense recommendations for 79403 without modification. In addition, the specialty requested that the practice expense relative value and non-physician work pool designation for code 79403 be crosswalked to CPT Code 78306.

Cytopathology, Selective Cellular Enhancement Technique (Tab 29) **Susan Spires, MD, FCAP, College of American Pathologists**

New code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)* has been created to encompass the new technology based on the Pap thinprep technique which provides for cell enrichment with concentration of specimens yielding more material for review with better preservation and more expanded application than were available based on smear preparations (88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* (Work RVU = 0.56)) or traditional cytoconcentrates (cytospin

billed as 88108 *Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)* (Work RVU = 0.56).

The specialty society explained that the relative work values of CPT codes 88104 and 88108 do not encompass the scope, intensity and impact of the service provided in the new CPT code 88112. These existing codes do not accurately capture the new cellular enhancement technologies, in the new code, that allows both concentration and enrichment of cytology specimens. Cytology specimens can be used on complicated specimens that could not be evaluated with typical concentration techniques.

The RUC reviewed the specialty society recommendations, survey results, and work values of other codes within the family of new CPT code 88112. The RUC understood that the new code allows the physician to review approximately 10,000 cells per slide, whereas codes 88104 and 88108 entails the review of less than 1,000 cells per slide. The median survey results support a work relative value of 1.20, however the specialty society indicated that the mean relative value of the survey (1.18 RVUs) would be more appropriate. The RUC believed that the new service required more physician time and a higher level of intensity than 88104 and 88108 from the specialty society's survey data and presentation, and supported the value as presented. **The RUC recommends a work relative value of 1.18 for CPT code 88112.**

Practice Expense

Attached are the direct practice expense inputs for new code 88112 reflecting a RUC change in the clinical staff type for some of the clinical activities.

Tumor Morphometry (Tab 30)

**Lester E. Wold, MD, FCAP, College of American Pathologists
Facilitation Committee #3**

One CPT code was revised and another added to properly describe the different processes of immunocytochemistry and morphometric analysis being performed typically by pathologists. CMS had initially asked that CPT codes 88342 *Immunocytochemistry (including tissue immunoperoxidase), each antibody* and 88358 *Morphometric analysis; tumor (eg., DNA ploidy)* be reviewed by the CPT Editorial Panel to clarify the service(s) being provided.

The RUC reviewed revised code 88358 and new code 88361 *Morphometric analysis; tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody*. The RUC reviewed the specialty society's recommendation and survey results for both codes and did not accept the initial specialty society work value recommendations.

The initial recommendations by the specialty were for a Work RVU of 1.20 for CPT code 88358 and 1.35 RVUs for 88361. The RUC discussed the

physician work of the two codes with the presenters, and agreed that the physician work for both codes were similar. With this in mind, the committee members believed that the specialty society's 25th percentile work survey results (0.95 for 88358 and 0.94 for 88361) more accurately reflected the physician work involved. The RUC members were satisfied with the median physician time components and believed the intra-service work per unit of time supported the recommended work RVUs.

RUC members reviewed code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) for its physician time and intensity. The committee believed that these two codes were aligned properly at the survey's 25th percentile RVUs with respect to the physician work and intensity of code 86077. **The RUC recommends the following relative values that reflect the 25th percentile of the specialty's survey results:**

Work RVU = 0.95 - 88358 *Morphometric analysis; tumor (e.g. DNA ploidy)*

Work RVU = 0.94 - 88361 *Morphometric analysis; tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody*

The specialty reassured the RUC that by now recommending a higher work RVU for 88358 than for 88361, a rank order anomaly would not be created. The specialty society representatives supported the recommendations of the RUC.

Practice Expense

The RUC reviewed the practice expense direct inputs for these two codes and made the following changes to the specialty society's recommendations:

- **The clinical labor time for both codes in the pre and post service time periods be designated as a Lab Technologist.**
- **The clinical labor time for CPT Code 88361 should be cross-walked to PEAC reviewed code 88342 *Immunocytochemistry (including tissue immunoperoxidase), each antibody***
- **Supplies were reduced for 88361:
Coverslip was reduced from 7 to 5
Label was reduced from 7 to 5
Microscope slide was reduced from 6 to 3**

A complete list of practice expense items approved by the RUC is attached to the recommendation.

Capsule Tract Imaging (Tab 31)

Maurtis Wiersema, MD, American Society of Gastrointestinal Endoscopy, Joel Brill, MD, American Gastroenterological Association Facilitation Committee #1

The CPT Editorial Panel created a new CPT code 91110 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* to describe this new approach to examine the gastrointestinal tract. In 2002, CMS had created Code G0262 *Small intestinal imaging; intraluminal, from ligament of Treitz to the ileo cecal valve, includes physician interpretation and report* (work rvu = 2.12) to report this new technology until CPT created a new code for *CPT 2004*.

In developing interim work relative values for code G0262, CMS relied on a comparison to the intra-service work per unit of time (IWPUT) derived by reviewing the work values and intra-service time for several services, including electroencephalography (EEG) reading and interpretation, magnetic resonance angiography (MRA), computed tomographic angiography (CTA), Holter monitoring reading and interpretation, prolonged esophageal acid reflux testing, echocardiography, duplex scanning of the carotid arteries, and anorectal manometry. Based on these comparisons, CMS determined that the average intensity measure of 0.04 should be applied to an intra-service time of 53 minutes, which they obtained from literature available in December 2002.

Gastroenterology subsequently conducted a survey of nearly 30 physicians who had experience in performing this service. The survey median work relative value was 5.80, with an intra-service time of 120 minutes. The specialty society chose to recommend the 25% work rvu of 5.00 to the RUC. The RUC, however, noted specific flaws in the survey instrument that may have led survey respondents to either misclassify post-operative work into the intra-service period and/or allocate physician time to certain clinical staff tasks. The RUC acknowledged that based on the analysis already completed by CMS, that the intra-service time for this service is critical to the appropriate valuation.

The RUC reviewed a recently published journal article published in the *European Journal of Gastroenterology and Hepatology* and agreed that the article's estimation of 80 minutes of intra-service time was reasonable. The RUC noted that the removal of the report writing time from the surveyed time and the time associated with services that are performed by clinical staff approximates 80 minutes.

The committee also extensively discussed the pre and intra service time associated with this service and compared this service to other diagnostic tests with a XXX global period. The committee recommends that a small amount of pre-service time (5 minutes) and 15 minutes of post-service time for report writing and other post-service activities are appropriate. The RUC recommends the following revised physician time: **Pre-Service Time: 5 minutes; Intra-Service time: 80 minutes; Post-Service Time: 15 minutes**

The RUC noted that it was very difficult to find a comparable reference service to link this new code to and offered that computing a value utilizing IWPUT offers the best alternative for this service. The facilitation committee agreed with the CMS analysis of similar codes with similar IWPUT as published in the *Federal Register* (0.04).

80 minutes intra-time x .040 intensity = 3.20 intra-work related to reading time

20 minutes of pre and post work x .0224 = .45

3.20 + 0.45 = 3.65

The RUC recommends a work relative value of 3.65 for 91110.

The RUC understands that a separate Evaluation and Management service may be reported on the same day as this service if a separately identifiable service is performed.

Practice Expense

The facilitation committee extensively reviewed the direct practice expense inputs and made several revisions, including significant reductions in the pre-service and service clinical staff times. A revised spreadsheet is attached to the recommendations.

Intracranial Artery Transcranial Doppler Studies (Tab A)

Michael Sloan, MD, James Anthony, MD, American Academy of Neurology

Two new codes were created by the CPT Editorial Panel to capture the extensive testing for cerebrovascular reactivity requiring more equipment, laboratory time, and expertise not provided for in the standard complete Transcranial Doppler study. Physicians had previously utilized both CPT Codes 93886 *Transcranial Doppler study of the intracranial arteries; complete study* and 93888 *Transcranial Doppler study of the intracranial arteries; limited study* to report the services described in the new codes. The CPT Editorial Panel created the two new codes as add-on codes, and the specialty society surveyed the entire family of codes because of work neutrality issues.

The RUC reviewed the specialty society's recommendations and survey results, and then came to the conclusion that the survey respondents evaluated the two new codes as separate procedures, and not as add-on codes. The vignette used in the survey did not represent the procedures as add-on codes. In addition, the specialty society explained that typically these new codes are not billed on the same day as the base codes. The RUC realized the survey results and the classification of these new codes as add-on codes was flawed,

and recommended the specialty redefine the codes with the assistance of the CPT Editorial Panel.

The CPT Editorial Panel has since rescinded these new codes and will consider this issue in the CPT 2005 cycle.

XI. Practice Expense Advisory Committee (PEAC) Update

Doctor Moran addressed the RUC to report on the recent activities of the Practice Expense Advisory Committee. Doctor Moran explained that the PEAC is presenting for RUC approval nearly 900 codes to the RUC from its January and March 2003 meetings. In addition, he explained that CMS is changing the schedule for implementing PEAC recommendations. Currently, the PEAC recommendations are submitted with the annual RUC recommendations in May for CMS publication in the Final Rule. CMS has decided to publish the PEAC recommendations in the Proposed Rule each year, which would mean for the 2004 Medicare Payment Schedule only the PEAC recommendations from September 2002 and January 2003 would be implemented in 2004. Also, since CMS requested the PEAC to refine the remaining E/M codes, these will also go into effect for 2004. By showing the effects of the PEAC recommendations in the Proposed Rule, specialties would have more time to comment on the recommendations. The PEAC recommendations from the March and August 2003 meetings and the January 2004 meeting would then be implemented in 2005.

The PEAC continued to standardize clinical labor inputs. The PEAC passed the following recommendation for 10 and 90 day global period codes that currently do not have a discharge day management code included in the global package: **Allocate 6 minutes of clinical staff time for discharge management for facility locations; unless there is CMS/RUC data (or specialty society input) to indicate that it is most commonly performed as an inpatient procedure. If there is data to support that a procedure is most commonly performed as inpatient, allocate 12 minutes of clinical staff time for discharge management.** The PEAC believes that when either a full discharge day or half a discharge day is assigned, the clinical staff work is the same and 6 minutes of phone call time should be allocated to represent the clinical staff discharge day activities. **Therefore, the PEAC agreed that for outpatient procedures with a half a discharge day, 6 minutes of clinical staff time should be allocated for these activities.**

Other standards developed by the PEAC include the following:

1. Practice expense input standards for conscious sedation
2. Cleaning times for scopes:
 - 5 minutes for disposable scopes
 - 10 minutes for a rigid scope
 - 30 minutes for a flexible scope

- 5 additional minutes of clinical staff time was set as the standard for setting up scopes in the non facility setting
3. Standard small and medium surgical instrument packages, including cleaning supplies. A large instrument package was not developed since the workgroup felt that such a package is not likely to be used in the office setting. Since the actual instruments used vary among specialties, the PEAC focused on the dollar amount for the two packages and recommended the following:
- Basic Surgical Instrument Package - \$500 and cleaning time of 10 minutes
 - Medium Surgical Instrument Package - \$1,500 and cleaning time of 15 minutes.
 - Cleaning supplies for scopes and instrument packages.

In addition, the PEAC completed in March an extensive refinement of over 100 additional E/M codes, through workgroup and facilitation committee meetings. The PEAC held an election for 3 rotating seats and elected Charles Shoemaker, MD, American Society of General Surgeons (ASGS) to the “any other” seat and Joel Brill, MD American Gastroenterological Association (AGA) and Richard Dickey, MD The Endocrine Society (TES) to the internal medicine seats.

The PEAC had some difficulty in evaluating a group of the percutaneous endovascular codes. There is no precedent or guidelines for establishing practice expense input recommendations for procedures once performed only in facility, but now these same procedures are performed in the office. PEAC members were reluctant to recommend a full set of inputs for the codes without information as to what impact a recommendation such as this would create. The PEAC will provide inputs at the specialty’s request however, what is really needed is a legislative level change in the law to allow funds to be shifted from Medicare Part A to Part B.

Doctor Moran also explained that PEAC members were questioning what will happen to practice expense refinement after the PEAC concludes in March, 2004. The PEAC has over 700 codes scheduled for each of the next two meetings and additional 300 scheduled for March 2004. Doctor Moran would like to have the last meeting open to finish up loose ends and to allow specialties to bring codes back if necessary so that the inputs are as accurate as possible.

AMA staff pointed out two additional items for RUC consideration. The first issue the PEAC reviewed code 54150 the PEAC felt the code should have XXX global period instead of its current 010 day global period. The RUC agreed with the PEAC’s recommendation, and made the following recommendation:

The RUC recommends that the global period for code 54150 be changed from a 010 day global to a XXX global code.

AMA staff also pointed out the RUC needed some mechanism for applying practice expense standards for those codes that may have been deleted and renumbered, then brought to the RUC for work and practice expense evaluations. The codes that were deleted may have had certain standards applied previously by the RUC, and when revised and/or renumbered the standards are lost. An example of this type of situation is the central venous access codes, where prior to revision and remuneration these codes were not eligible to have pre-service clinical labor staff time, and when they were revised and renumbered the specialty asked for the maximum pre-service time. The RUC agreed that this was a problem and the following recommendation was made and accepted by the full RUC.

If CPT Codes are revised and renumbered the pre-service clinical labor time will be zero until the specialty can provide evidence to the RUC that any pre-service time is appropriate.

XII. RUC HCPAC Review Board Report

The RUC HCPAC Board was updated on the Relative Value recommendations for the CNS Assessments/Tests, to assess the recommendations for Rehabilitation Assessment and Integration Services codes and to elect a new HCPAC Co-Chair and Alternate Co-Chair. The update on the CNS Assessments/Tests included a brief history of the recommendation process for these codes and future plans for surveying including using the standard RUC survey instrument in this current evaluative process. APA stated that they will present the new recommendations at the September 2003 HCPAC meeting. The relative value recommendations for the Rehabilitation Assessment and Integration Services were presented by Mary Foto, OT. These recommendations were assessed, modified and approved by the HCPAC.

Mary Foto, OT and Nelda Spyres, LCSW were elected RUC HCPAC Co-Chair and Alternate Co-Chair, respectively. Their terms will begin with the September 2003 RUC HCPAC Review Board Meeting.

The full report of the RUC HCPAC Review Board is attached to the minutes.

XIII. Zero Work Pool Workgroup Report

Doctor Britton presented the report of the zero physician work pool workgroup. Doctor Britton summarized the report and concluded that since several specialties with codes in the zero physician work pool are working with CMS to collect additional stratified practice expense data and since all for the codes in the pool are scheduled to be refined through the PEAC

process, any further RUC action on this issue would be premature. The workgroup preferred to wait until these activities are completed before reexamining the issue and determining what, if any, role the RUC should have in this issue.

The full report of the Zero Work Pool Workgroup is attached to the minutes.

XIV. Conscious Sedation Workgroup Report

Doctor Lanny Garvar presented the Conscious Sedation Workgroup Report for William Gee, Chairman of the Conscious Sedation Workgroup. At this meeting the workgroup finalized a list of 229 CPT codes that inherently include conscious sedation. The workgroup also agreed that additional codes will be added from the Central Venous Access Issue once these practice expense recommendations have been finalized. *Staff Note: The following 18 CVA codes were identified in late May as inherently including conscious sedation. These codes have been sent to the CPT Editorial Panel to consider, along with the 229 codes from the list approved at the April RUC meeting.*

CPT Code	Description
36555	Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age
36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age
36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older
36560	Insertion of tunneled centrally inserted central venous access device with subcutaneous port; under 5 years of age
36561	Insertion of tunneled centrally inserted central venous access device with subcutaneous port; age 5 years or older
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36565	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump, (eg, Tesio type catheter);
36566	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, under 5 years of age
36570	Insertion of peripherally inserted central venous access device with subcutaneous port; under 5 years of age
36571	Insertion of peripherally inserted central venous access device with subcutaneous port; age 5 years or older

36576	Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36582	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access
36583	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access
36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access
36590	Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion

The RUC recommends the adoption of the attached list of 229+ CPT codes (plus new codes from this RUC meeting) as representing those services that inherently include conscious sedation.

Doctor Gavar presented the document *Recommendation to the CPT Editorial Panel* to the RUC for review. The American Academy of Pediatrics noted that the RUC should also recommend revision to the Anesthesia section to clarify that when any physician, other than the physician performing the procedure, provides anesthesia service (conscious sedation or otherwise), the Anesthesia codes should be reported.

The RUC adopted the following recommendations and will forward them to the CPT Editorial Panel for consideration:

- 1. The CPT Editorial Panel should consider the addition of an Appendix in CPT to specifically identify the 229(+) CPT codes which inherently include conscious sedation, provided by the operating physician. This list may be updated annually as new CPT codes are added or to address codes where changes in practice lead to changes as to whether conscious sedation is inherently included. Addition or deletion of codes from the list must be approved by the RUC and submitted to the CPT Editorial Panel.**
- 2. The Appendix should include an explanatory note that “the inclusion of a procedure on this list does not prevent separate reporting of an associated anesthesia procedure/service (CPT codes 00100-01999) when performed by a provider (such as an anesthesiologist or CRNA) other than the operating physician.”**
- 3. Revision to the CPT codes for conscious sedation (99141 and 99142) and addition of new add-on codes to allow the reporting of conscious**

sedation on an increment of conscious sedation time during the procedure. A cross-reference directing the user to the new Appendix should also be added to these codes.

99141 Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation; initial 15 minutes

991X1 each additional 15 minutes

99142 Sedation with or without analgesia (conscious sedation); oral, rectal, and/or intranasal; initial 15 minutes

991X2 each additional 15 minutes

After the CPT Editorial Panel acts on this recommendation, these codes will flow through the RUC process for evaluation.

- 4. Revision to the Anesthesia section notes in CPT to clarify that the reference to the conscious sedation codes only applies to physicians who are performing the procedure. A clarification should be made that when any physician, other than the physician performing the procedure, provides anesthesia services (conscious sedation or otherwise), the Anesthesia codes should be reported.**

The Conscious Sedation Workgroup Report was approved and is attached to these minutes.

XV. Practice Expense Subcommittee Report

The Practice Expense Subcommittee met during the April 2003 RUC meeting to continue its work on the allocation of physician time components, and discuss a mechanism of adding a non-facility practice expense component. Doctor John Gage, MD presented the following report concerning the business of the practice expense subcommittee.

The RUC reiterated their concern that specialties may use the physician time allocations of physician time components to alter work values any time in the future. The subcommittee believed that specialties may try to use their survey results and allocations for the next 5 year review, and believed that this should be prevented. The RUC reiterated that the purpose of the time allocations was to help the PEAC determine clinical staff labor practice expense time, as it is driven by physician time.

The RUC stressed that total time for all 227 codes and others where CMS cross-walked the physician time should not be submitted to CMS at all, but that only the allocations and surveyed physician time components that would

facilitate the PEAC's practice expense refinement should be forwarded. The RUC recommended that:

The physician time components will be accepted as presented, as needed to facilitate the PEAC's process. In addition, these codes will be asterisked in the RUC database, and the total time should not be entered into the CMS database for their practice expense methodology.

The full report of the Practice Expense Subcommittee is attached to the minutes.

XVI. Administrative Subcommittee Report

Doctor Gregory Przybylski presented the Administrative Subcommittee minutes. Regarding the Five-Year Review:

The RUC recommends that the duration between reviews should be maintained at five year intervals.

In addition, the RUC accepted the following recommendation from the Administrative Subcommittee:

Going forward with review of new and revised codes, societies will be encouraged, where applicable, to address at the same time, not only the individual new or revised codes, but also anticipated resulting problems with a related family of codes.

Staff Note: On May 2, 2003, staff clarified that this information would not be added to the Instructions to Specialty Societies for Developing Work Relative Value Unit Recommendations, rather specialty societies should notify RUC staff of any resulting problems prior to presenting new or revised codes at the CPT Editorial Panel Meeting.

The full Administrative Subcommittee report was approved and is appended to these minutes.

XVII. Research Subcommittee Report

Doctor Borgstede presented the Research Subcommittee report. Due to a change in the definition of codes with ZZZ global periods, the RUC discussed how these codes should be reviewed. If the change affects practice expenses, then the PEAC may examine the codes during refinement, but if physician work is affected, the review should take place during the next five year review.

The RUC passed the following recommendation:

Review ZZZ codes and the associated base code that may be affected by the definition change as part of the next five-year review. (To begin in Fall, 2004)

The RUC concluded that before making any changes to the pre-service time period definitions for 000 and 10 day global period codes, the RUC would like to obtain more information for consideration during the next RUC meeting. Specifically, the RUC passed the following motion:

Identify the number of 000 and 10 day global period codes that the RUC has reviewed using the current pre service definition so the subcommittee can review this information at the September, 2003 RUC meeting.

The RUC discussed the last action item relating to IWPUT calculations for the codes on the IWPUT list. Doctor Borgstede clarified that only those codes list as category A are eligible to have an IWPUT assigned. Before publishing any IWPUTs, the Subcommittee felt that the IWPUTs need to be shared with all the specialties and get comments and then be discussed by the RUC. Additionally, the calculations will be performed using the RUC approved formula and using the data in the RUC database. Doctor Lichtenfeld asked that the following be added to the recommendation: The data source and IWPUT calculation formula should also be provided to the RUC. This resulted in the following recommendation approved by the RUC:

The IWPUT for all Type A codes on the MPC list should be calculated for review by the Research Subcommittee. This would involve first allowing specialties an opportunity to comment on each code and indicate if the IWPUT should be listed on the MPC. The data source and IWPUT calculation formula should also be provided to the RUC.

The RUC approved to file the report.

XVIII. Anesthesia Five-Year Review

Doctor Hoehn presented the RUC Anesthesia workgroup Report since Doctor Mayer had to leave the RUC meeting. Doctor Hoehn reminded the RUC that it was looking at this issue again due to a request from CMS Administrator Tom Scully. Doctor Hoehn read the following three recommendations contained in the report and then asked if there were any extractions:

- The RUC position is that the 5 year review has been completed.
- The RUC anesthesia workgroup analysis only applies to the 19 anesthesia codes and associated 19 surgical codes.
- The WG recommends to the RUC that the following list of structural differences between the anesthesia coding system and the remainder of the physician coding system, which contribute to the difficulties in making extrapolations to the entire set of anesthesia services, be

forwarded to CMS administrator Scully in response to his letter of February, 2003.

The first and third recommendations were approved and the second recommendation was extracted for discussion.

Doctor Cohen explained that the ASA disagrees with the workgroup's second recommendation since there is no basis that the workgroup's analysis apply only to the 19 surgical codes associated with each of the 19 anesthesia codes. Since the full RUC did not examine each individual anesthesia code last April, and did not specify the number of surgical codes that should be included in that analysis, Doctor Cohen questioned how the RUC could make such an explicit recommendation this time. Also, after the RUC received the request from the CMS Administrator in February, ASA proposed that the RUC identifying the surgical codes to which the anesthesia work values were applicable, but according to Doctor Cohen, the workgroup did not accomplish this objective since each individual anesthesia code was not separately examined.

Doctor Hoehn requested that Doctor Cohen's entire statement be included in the RUC minutes if recommendation two is accepted as proposed. Doctor Lichtenfeld commented that if the entire ASA statement is included, the minutes should also reflect that the reason the RUC can not do any better in its review of anesthesia work values is due to the existence of a separate system of coding physician services and therefore anesthesia services should be placed on the RBRVS.

Doctor Cohen presented the following statement to the RUC.

ASA Comments on RUC Anesthesia Workgroup Report and Recommendations

The anesthesia 5 year issue has proven to be among the most complex, difficult tasks undertaken by the RUC in recent memory. The workgroup has made three recommendations to the RUC to answer Mr. Scully's request.

We agree with the workgroup about two things - the 5 year review is over and that it is appropriate to communicate the difficulties encountered along the way.

Beyond that, we disagree with the Workgroup's recommendation. We do not believe that the second action item under consideration is justified by the RUC activities since last April when this topic was last addressed by the full RUC.

Specifically, there is absolutely no basis for the finding that the study work value results apply only to the 19 surgical codes used to create survey vignettes. Let me explain.

The full RUC did not consider the code-by-code application of the study results when the issue was deliberated last year. As a consequence, the RUC only forwarded the workgroup documents without comment on defining the universe of anesthesia work addressed by the study.

Earlier this year, both CMS and ASA requested that this exercise be completed by precisely identifying the surgical codes to which the anesthesia work values were applicable.

The workgroup explicitly decided not to undertake this task. The full RUC has likewise not taken this on.

In the absence of such a deliberation by either the workgroup or the full RUC, how can we report to CMS that any particular number of codes – be it 10, 19, 75 or 200 – is the right number?

How would you explain that the anesthesia work for two knee arthroscopy procedures with virtually identical intra-service times and descriptors is not the same?

How can you answer that same question with the cystourethroscopy codes, where half a dozen codes have intra-service times differing by less than 2 minutes from the studied code?

Neither the workgroup nor the full RUC has come close to addressing these questions, yet the proposal is that the RUC identify a specific number of surgical procedures for which a work value crosswalk is appropriate.

Compared to last April when the RUC forwarded study data without comment, no new information has come before you - you cannot make a new statement limiting the analysis to any specific number of codes without new findings. The RUC can say no more or less than it did last year. The only appropriate RUC action is to report that no new information is available for CMS at this time and the Workgroup's report on the difficulties it encountered will provide the explanation of this situation.

Doctor Rich stated that the workgroup did discuss the appropriateness of including more than the 19 surgical codes in the analysis as well as extrapolating the workgroups results beyond the 19 anesthesia codes. Statements on this topic are reflected in the recent workgroup minutes. Last year the RUC recommendation was somewhat ambiguous since it basically stated that the RUC was unable to extrapolate, but this time the workgroup did discuss whether the workgroup results could be extrapolated beyond the 19 anesthesia and surgical codes and concluded that the results could not be extrapolated.

Doctor Cohen clarified that the only extrapolation being discussed is specifying the number of surgical codes to be included in the analysis, and not the larger extrapolation issue that would apply the results of the work study to all anesthesia codes. Doctor Cohen reiterated that the RUC has not analyzed the workgroup report to make a recommendation that for each of the 19 Anesthesia codes, only the associated 19 surgical codes can be used in the analysis.

Doctor Hannenberg also clarified that the recommendation before the RUC is not equivalent to saying that the study results do not apply to all the surgical codes or that saying that the RUC does not know how many surgical codes should be included. Unless the RUC is prepared to examine each of the anesthesia codes and the surgical codes included in the anesthesia crosswalk lists, then the RUC can not vote in favor of the workgroup recommendation, since the RUC does not know the number of surgical codes that should be included. The workgroup and the RUC has not conducted the analysis necessary to make a recommendation specifying a specific number of codes and the issue deserves no further action than was taken last year.

Doctor Lichtenfeld stated that the RUC has done its best to study the anesthesia issue and has spent a considerable amount of time since the five-year review to resolve the issue. The third recommendation that lists the seven structural differences makes it clear that the RUC has tried its best to resolve the anesthesia issue.

The RUC then passed the second recommendation, resulting in the approval of the following recommendations:

- **The RUC position is that the 5 year review has been completed.**
- **The RUC anesthesia workgroup analysis only applies to the 19 anesthesia codes and associated 19 surgical codes.**
- **The WG recommends to the RUC that the following list of structural differences between the anesthesia coding system and the remainder of the physician coding system, which contribute to the difficulties in making extrapolations to the entire set of anesthesia services, be forwarded to CMS administrator Scully in response to his letter of February, 2003.**

1. The RUC felt that a comparison between two different systems; the time based anesthesia system and the RBRVS system where time is fixed for each code, did not allow for a valid comparison.
2. The vignette selected may not have been accurate or the selected surgical code was not representative of the entire family of surgical codes.
3. An analysis of a single anesthesia code based on a single surgical code was insufficient when the anesthesia code covers a large number of surgical codes. The workgroup indicated for each anesthesia code its confidence in the number of surgical codes that should be included in the analysis and in many cases the extrapolation was limited to select surgical codes.
4. For those anesthesia codes that cover a large number of surgical codes, there was a concern that smaller families would be needed due to the variability in intensity and time among the surgical codes. Due to the variability in time and intensity the analysis based on a single surgical code could not always be applied to all surgical codes in the anesthesia family. This reasoning also applied to extrapolating the results of the 19 anesthesia codes to all anesthesia codes due to the variability in the associated surgical codes.
5. The RUC was not convinced based on the data presented that the results of the 19 anesthesia code analysis could be extrapolated to the remainder of the anesthesia codes. A workgroup member attributed this unwillingness to extrapolate due to RUC not having the statistical confidence to determine if extrapolating the analysis of the 19 anesthesia codes to all anesthesia codes would be valid.
6. Although the RUC recommended extrapolation in the first five-year review the RUC did not make a similar recommendation in the second five-year review. This was because there has been an evolution in the RUC process where now the RUC uses new data such as IWPUR, and has better physician time data and better understanding of intensity. Also, the RUC had a much more detailed methodology for reviewing the anesthesia codes than it did in the first five year review.
7. There was a concern that the 19 selected anesthesia codes may not be the most representative anesthesia codes. Although these are the highest volume codes there was concern whether this was the right type and number of anesthesia codes. This concern is closely related to the other concerns about basing a change in value for over 200 codes based on an analysis of only 19 codes. Specifically, there was a concern that 4 of the 19 surgical codes selected were vascular surgery codes and this seemed to create an overemphasis on vascular surgery procedures, possibly skewing the analysis. Given the wide range of intensity and time among the surgical codes within each of the 19 families, there was a concern that there could also be great variations between the 19 anesthesia codes and all other anesthesia codes. It was suggested by a workgroup member that there may need to be

additional anesthesia codes included in the analysis in order to support extrapolation from a small subset of codes to all other anesthesia codes.

The RUC then approved a motion to file the anesthesia workgroup report. Doctor Hoehn commended Doctor Mayer all the members who served on of the anesthesia workgroups for the extensive discussion, and effort that they have given the anesthesia issue. Doctor Hoehn also noted that no other specialty society has been afforded the amount of time, effort and detail that has gone into the debate on this issue.

XIX. Other Issues

A request was made by a RUC member to develop a standard instruction sheet for XXX global period codes. This issue will be referred to the Research Subcommittee for review and development.

A Physician Liability Insurance (PLI) Workgroup will be established to examine increasing concerns regarding liability insurance. Volunteers for the workgroup include: Doctors Przybylski, Pfiefer, and Reed. Other volunteers are encouraged to submit their names to AMA Staff.

As the PEAC will sunset within the next two years, Doctor Rich proposed that at the next RUC meeting, a PEAC transition workgroup be formed to determine how the PEAC methodology can be better incorporated into the RUC process.

The RUC revisited the concern that shifts in site of practice from in the facility to out of the facility are shifting funds are not addressed with additional allowed expenditures in the SGR formula. Members also questioned the extent to which the practice expense pools for non-facility and facility are affected. To address the broad issue, Doctor Truagott is developing a resolution to be discussed before the AMA House of Delegates. This resolution will be circulated to the RUC for their input.

The April Meeting was Doctor Hoehn's last meeting as RUC Chair before Doctor Rich assumes this position. The RUC expressed its appreciation for Doctor Hoehn's outstanding contributions to furthering the success and ensuring the longevity of the RUC structure and functions, and the process.

The meeting was adjourned at 10:30 am on Sunday, April 27th, 2003.

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

January 27-29, 2003

Orlando, Florida

Bill Moran, MD (Chair)	Scott Manaker, MD
James Anthony, MD	James Metcalf, MD
Deborah Bash, MD	Tye Ouzounian, MD
Katherine Bradley, PhD, RN	Julia Pillsbury, DO
Ann Cea, MD	Dighton Packard, MD
Manuel D. Cerqueira, MD	James Regan, MD
Neal Cohen, MD	Anthony Senagore, MD
Thomas A. Felger, MD	Ronald Shellow, MD
Blair Filler, MD	Daniel Mark Siegel, MD, MS
Mary Foto, OTR	Robert Stomel, DO
David Hoak, MD*	Craig Strafford, MD
Ronald Kaufman, MD	Peter Weber, MD
Gregory Kwasny, MD	Charles Weissman, MD
Alex Little MD	Lester Wold, MD
Peter McCreight, MD	

*Alternate PEAC Member

Doctor Moran welcomed the following new PEAC Members

Scott Manaker, MD -- ACP
Peter McCreight, MD – ACR
Peter Weber, MD – AAO-HNS
Lester Wold, MD -- CAP

CMS Update

CMS is changing the schedule for implementing PEAC recommendations. Currently, the PEAC recommendations are submitted with the annual RUC recommendations in May for CMS publication in the Final Rule. CMS has decided to publish the PEAC recommendations in the Proposed Rule each year, which would mean for the 2004 Medicare Payment Schedule only the PEAC recommendations from September 2002 and January 2003 would be implemented in 2004. By showing the effects of the PEAC recommendations in the Proposed Rule, specialties would have more time to comment on the recommendations. The PEAC recommendations from the March and August 2003 meetings and the January 2004 meeting would then be implemented in 2005.

Carolyn asked the PEAC to specifically review the standard that is used to assign clinical staff time during the intra-service period. Each code should be reviewed to determine if

Approved at the April 2003 RUC Meeting

the nurse is present for the entire time. In the past, either 1/2, 2/3rds or 100% of the physician intra-service time has been assigned. The PEAC discussed that the clinical staff time needs to be examined on a code by code basis and for invasive surgical procedures in an office setting, it is probably appropriate that the clinical staff be present for the same time that the physician is present, however, for all other codes the PEAC clinical staff may or may not be present during the entire procedure.

Discharge Day Management

The PEAC had previously asked the RUC Practice Expense Subcommittee to examine all the 10 and 90 day global period codes that do not have a discharge day management codes included in the global package. The PEAC asked the RUC to apply the discharge day management codes in a standard manner to facilitate the assignment of practice expenses. The RUC is in the process of allocating discharge day management codes, but several specialties have asked the PEAC to examine this issue and develop an alternative proposal that differs from the current RUC proposal. The proposal suggested the PEAC and RUC should look not only at where the procedure is predominately performed, either in the facility or in the office, but also when the surgical procedure is performed in the facility, whether is it done as an inpatient procedure or an outpatient procedure. The suggestion is to assign discharge day management for the facility setting based on whether the code is more frequently performed in the inpatient or outpatient setting. If it is an outpatient setting, 6 minutes should be assigned, and if it is more frequently performed in the inpatient setting then 12 minutes should be assigned. These facility time assignments should be assigned regardless of the frequency that occurs in the office setting. This should apply to all 10 or 90 day codes that currently do not have a discharge day assigned in the current RUC database.

The PEAC agreed that discharge day should be assigned in the facility setting based on the dominant setting. For the office setting, the PEAC did not agree that discharge day time should be automatically assigned. Rather, if a procedure is performed in the office setting, the specialty society should justify any follow-up phone calls that should be assigned to the at office setting. This review should be on a code by code basis.

The PEAC passed the following recommendation for 10 and 90 day global period codes that currently do not have a discharge day management code included in the global package:

Allocate 6 minutes of clinical staff time for discharge management for out-of- office locations; unless there is CMS/RUC data (or specialty society input) to indicate that it is most commonly performed as an inpatient procedure. If there is data to support that a procedure is most commonly performed as inpatient, allocate 12 minutes of clinical staff time for discharge management.

The PEAC also reviewed the times associated with the discharge day management codes. For inpatient procedures the codes should receive 12 minutes based on 6 minutes of discharge day calls and well as 6 minutes of calls that occurred over the hospitalization period. This additional 6 minutes was characterized as coordination of care activities. To apply this time, the PEAC previously agreed to add the 6 minutes to discharge day management time. For outpatient procedures with a half day discharge, the PEAC

discussed whether 3 or 6 minutes should be the standard time assigned. The PEAC felt that when either a full discharge day or half a discharge day is assigned, the clinical staff work is the same and 6 minutes of phone call time should be allocated to represent the clinical staff discharge day activities. **Therefore, the PEAC agreed that for outpatient procedures with a half a discharge day, 6 minutes of clinical staff time should be allocated for these activities.**

Cleaning of Endoscopes

The PEAC agreed to form a workgroup that examines the time it takes to clean endoscopes. The PEAC discussed the differences in cleaning times for different types of scopes. The PEAC agreed that even for disposable scopes there is an eyepiece that requires cleaning. As an interim measure, the PEAC developed several standard cleaning times.

The PEAC reconfirmed the existing standard of 3 minutes for cleaning the room. This will be set as a base time with additional time allowed for cleaning scopes.

- 5 minutes for a disposable scope,
- 10 minutes for a rigid scope, and
- 20 minutes for a flexible scope

Standardization of Surgical Instrument Packages

During the review of a number of procedures performed in the office, the PEAC discussed the need to standardize surgical instrument packages. The inclusion of surgical instruments as equipment has not been applied uniformly. The PEAC felt that the development of three packages such as minor, medium, and major package would facilitate the refinement process. Although there is great variability among specialties in the types of instruments typically used, the PEAC felt that generic packages could be developed, and as long as the dollar amount for each package was similar to a specialty specific package, the generic packages could be used by all specialties. In addition to developing packages, the PEAC felt that clinical staff time to clean the instruments should be developed for each package. Typically the PEAC has not allocated time for the cleaning of instruments. A PEAC workgroup will be formed to develop a recommendation concerning instrument packages.

E/M Codes performed on the Same day as a Procedure

The PEAC has been using E/M frequency data provided by CMS to determine those codes that are typically performed with an E/M. The PEAC has traditionally reduced the clinical staff time of the procedure code for those codes that are performed on the same day as an E/M. Clinical staff activities such as greet patient, and obtaining vital signs have been adjusted to reduce double counting. The PEAC agreed that:

The time included in the pre-service standard times for pre-service education/obtain consent should be reduced to zero when the code is typically performed with an E/M code in the office setting, however, the PEAC agreed that 3 minutes of education was appropriate during the service period in the office setting.

Orthopedic Surgery

AAOS presented a large family of codes and 11 codes were deferred because it was determined that podiatry was the primary provider of those codes. Podiatry will present inputs for those codes at a future PEAC meeting. AAOS developed standard supplies for all of the codes to make the inputs as consistent as possible since the set up for all procedures is standardized in orthopedic surgery practices. AAOS presented standard inputs such as double gloving, shoe covers and particular draping techniques. It was explained that these standards are used by orthopedic surgeons due to work involved in joints and exposed bones. The pre-facilitation committee reviewed the proposed standards in detail and agreed that the approach to make all codes in the family have standard inputs. The PEAC was concerned that for those codes where Orthopedic surgery was not the dominant provider, these standard orthopedic supplies would not be appropriate. In addition, for less invasive codes, the PEAC would like to see a reduction in the supplies. The PEAC discussed this issue at length and did not approve the use of a standard supply package for all the orthopedic surgery codes presented to the PEAC. The PEAC approved the supplies and clinical labor for codes 10121, 10180, 11010, 11011, and 11012. For all the other codes, only the clinical labor time was approved and AAOS will present revised supplies and equipment recommendations at the March PEAC meeting.

Conscious Sedation Workgroup

The conscious sedation workgroup presented a recommendation for PEAC consideration. The workgroup was comfortable with the current conscious sedation standards that has been used by the PEAC and felt that these standards should be applied to the stand alone codes, however, the workgroup also felt that new codes should be developed. Given that the conscious sedation codes would be used with a wide variety of procedures with highly variable intra-service times, the workgroup was unable to come up with a standard intra-service time for conscious sedation. In developing the standard for the injection codes, the PEAC set the intra-service conscious sedation time equal to the physician intra-service time for the procedure. Since the stand alone codes will be used with a variety of procedures, developing a single stand time would not be appropriate. To account for the variability in procedure time the workgroup developed the concept of base and add on codes for conscious sedation. The base code would include all the supplies and equipment, the 2 minutes to initiate sedation, 15 minutes of intra-service time, and the 15 minutes of follow-up monitoring. The add on codes would only account for the additional intra-service time, in increments of 15 minutes.

The PEAC approved the following recommendation:

The following times and supplies and equipment should be assigned to the conscious sedation base codes.

Clinical Labor:

RN – 2 minutes to initiate sedation

RN – 15 minutes of follow-up monitoring

Medical Supplies:

Pulse oximeter probe

gown, staff

gloves (sterile)

swab alcohol (2)

band aid

Gauze, sterile, 4x4 (4)

tape, 6 inches (12)

Tegaderm dressing 4x4 ¾

Oxygen, 1 ltr (200)

ECG electrodes disposable

Angiocatheter 20 to 25g

IV infusion set

Stopcock, 3 way

IV starter kit

Syringe, 3 cc, 20 to 25 g (2)

Syringe, 1 ml

rubber tourniquet

Suction tip catheter

O2 mask and tubing

Medical Equipment:

cardio-respiratory

monitor

infusion pump

pulse oximeter

oxygen tank

To account for the variability in the intra-service time in the procedure codes that would be reported with the stand alone conscious sedation codes, the PEAC agreed that new conscious sedation codes would need to be developed.

The following conscious sedation coding concept was approved by the PEAC:

A conscious sedation base code would include all the supplies, equipment, the 2 minutes to initiate sedation, 15 minutes of intra-service time, and the 15 minutes of follow-up monitoring. The add on codes would only account for the additional intra-service time, in increments of 15 minutes.

Other Issues

- The PEAC voted on a standard of 2 minutes to position and prepare the patient in the office setting.
- The PEAC voted on a standard of 2 minutes to prepare room, equipment and supplies.

- If the pre-service time period includes time for providing pre-service education and obtaining consent then time for these activities should not also be included in the service period.
- The PEAC agreed that code 54150 *Circumcision, using clamp or other device; newborn* should have a global period of XXX. The PEAC recommends that specialty societies request CMS to change the global period.

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

PEAC Conscious Sedation Conference Call Minutes

January 9, 2003

The following members participated in the conference call to discuss the practice expense inputs for codes 99141 and 99142: Doctors Anthony Senagore (chair), Neal Cohen, Charles Mick, Julia Pillsbury, Tim Shahbazian, and Maurits Wiersema.

Since the PEAC request to refine the conscious sedation (CS) codes originated with the RUC, the workgroup members received an overview of the RUC conscious sedation workgroup's efforts to date. Sherry Smith explained that the issue originated during the second five-year review when the GI societies argued that the physician work for some codes changed due to the additional work associated with conscious sedation. A number of the GI codes were described as always being performed with CS and an increase in physician work was warranted due to increased documentation and other factors. The RUC has been examining this issue ever since the five-year review and has asked specialty societies to identify those codes that in today's practice inherently include conscious sedation. The RUC intends to compile a list of codes that inherently include conscious sedation provided by the physician performing the procedure. These should only be services where the sedation services are administered by or under the supervision of the operator (physician performing the procedure). If conscious sedation is an inherent part of the procedure, but is most typically provided by an anesthesiologist or CRNA, the code should not be included on this conscious sedation list. The goal would be to submit a list of codes to CPT so that they could be designated as including conscious sedation.

The RUC will then examine the work and practice expense inputs for the CS codes. The PEAC will make a recommendation to the RUC regarding the PE inputs.

The workgroup members examined the current CS package that has been used by the PEAC for spine injection procedures and sigmoidoscopy procedures. The workgroup was comfortable that these inputs were appropriate for codes that typically include conscious sedation. The workgroup discussed the CS stand alone codes and began reviewing the inputs for those codes. The workgroup was comfortable with the current standard of 2 minutes to initiate the sedation and the 15 minutes of follow-up monitoring for each hour monitored following the procedure. Since the use of CS requires by regulation, one hour of monitoring, the 15 minute monitoring standard would be appropriate.

Given that the CS codes would be used with a wide variety of procedures with highly variable intra-service times, the workgroup was unable to come up with a standard intra-service time for CS. In developing the standard for the injection codes, the PEAC set the intra-service CS time equal to the physician intra-service time for the procedure. Since the stand alone codes will be used with a variety of procedures, developing a single stand

Approved at the April 2003 RUC Meeting

time would not be appropriate. To account for the variability in procedure time the workgroup developed the concept of base and add on codes for CS. The base code would include all the supplies, equipment, the 2 minutes to initiate sedation, 15 minutes of intra-service time, and the 15 minutes of follow-up monitoring. The add on codes would only account for the additional intra-service time, in increments of 15 minutes.

The workgroup members also discussed the difficulty in receiving Medicare reimbursement for the CS drugs when CS is provided in the office setting. Various methods were discussed including writing a prescription and having the drug delivered to the office. Several of the workgroup members have not been reimbursed by Medicare for CS. The workgroup members would like the CMS officials that attend the PEAC to discuss the Medicare payment policies regarding reimbursement for CS drugs. The workgroup members felt that this was a critical issue that needs to be resolved in terms of ensuring proper accounting for CS practice expenses.

The Workgroup will meet again on January 28, 2003 and will at that time finalize its recommendation.

CPT Codes Refined by the PEAC in January 2003

<i>CPT Code Refinement *</i>	<i>Global Specialty(s) Involved</i>	<i>Descriptor</i>	<i>Extent of</i>
10080		Drainage of pilonidal cyst	ASGS, ASCRoS, ACS
10081		Drainage of pilonidal cyst	ASGS, ASCRoS, ACS
10121		Remove foreign body	ASGS, AAOS, ACS
10180		Complex drainage, wound	ASGS, AAOS, ACS
11010		Debride skin, fx	ASGS, AAOS, ACS
11011		Debride skin/muscle, fx	ASGS, AAOS, ACS
11012		Debride skin/muscle/bone, fx	AAOS
11044		Debride tissue/muscle/bone	AAOS
11200		Removal of skin tags	AAFP
11201		Remove skin tags add-on	AAFP
11770		Removal of pilonidal lesion	ASGS, ACS
12020		Closure of split wound	AAOS
12021		Closure of split wound	AAOS
12032		Layer closure of wound(s)	ASGS
12035		Layer closure of wound(s)	ASGS, ACS
12036		Layer closure of wound(s)	ASGS, AAOS, ACS
12037		Layer closure of wound(s)	ASGS, AAOS, ACS
12045		Layer closure of wound(s)	ASGS, AAOS
12046		Layer closure of wound(s)	ASGS, ACS
12047		Layer closure of wound(s)	ASGS, ACS
19000		Drainage of breast lesion	ACS, ASGS, ACOG, ACR
19140		Removal of breast tissue	ACS
19160		Removal of breast tissue	ACS
19162		Remove breast tissue, nodes	ACS
19180		Removal of breast	ACS
19182		Removal of breast	ACS
19200		Removal of breast	ACS
19220		Removal of breast	ACS
19240		Removal of breast	ACS
19260		Removal of chest wall lesion	ACS
19271		Revision of chest wall	ACS
19272		Extensive chest wall surgery	ACS
20000		Incision of abscess	AAOS
20005		Incision of deep abscess	ASGS, AAOS, ACS
20103		Explore wound, extremity	ASGS, AAOS, ACS
20200		Muscle biopsy	ACS, ASGS
20205		Deep muscle biopsy	ACS, ASGS
20240		Bone biopsy, excisional	AAOS
20245		Bone biopsy, excisional	AAOS
20520		Removal of foreign body	AAOS
20525		Removal of foreign body	ASGS, AAOS, ACS
20615		Treatment of bone cyst	AAOS
20650		Insert and remove bone pin	AAOS
20660		Apply,remove fixation device	NASS
20665		Removal of fixation device	NASS
20950		Fluid pressure, muscle	AAOS
20974		Electrical bone stimulation	AAOS
20975		Electrical bone stimulation	AAOS
20979		Us bone stimulation	AAOS
21550		Biopsy of neck/chest	ASGS, ACS
21920		Biopsy soft tissue of back	ASGS, ACS
22505		Manipulation of spine	NASS, AAPM&R

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 1 of 10

CPT Code Refinement *	Global Specialty(s) Involved	Descriptor	Extent of
22520		Percut vertebroplasty thor	NASS, AAPM&R
22521		Percut vertebroplasty lumb	NASS, AAPM&R
23030		Drain shoulder lesion	AAOS
23031		Drain shoulder bursa	AAOS
23065		Biopsy shoulder tissues	ASGS, AAOS, ACS
23075		Removal of shoulder lesion	ASGS, AAOS, ACS
23330		Remove shoulder foreign body	AAOS, ACS
23700		Fixation of shoulder	AAOS
23930		Drainage of arm lesion	ASGS, AAOS, ACS
23931		Drainage of arm bursa	AAOS
24065		Biopsy arm/elbow soft tissue	ASGS, AAOS, ACS
24200		Removal of arm foreign body	ASGS, AAOS, ACS
24640		Treat elbow dislocation	AAOS
25065		Biopsy forearm soft tissues	AAOS
26010		Drainage of finger abscess	AAOS
26011		Drainage of finger abscess	AAOS
27040		Biopsy of soft tissues	ASGS, AAOS, ACS
27086		Remove hip foreign body	AAOS
27256		Treat hip dislocation	AAOS
27257		Treat hip dislocation	AAOS
27275		Manipulation of hip joint	AAOS
27323		Biopsy, thigh soft tissues	ASGS, AAOS, ACS
27570		Fixation of knee joint	AAOS
27605		Incision of achilles tendon	AAOS
27606		Incision of achilles tendon	AAOS
27613		Biopsy lower leg soft tissue	ASGS, AAOS, ACS
27860		Fixation of ankle joint	AAOS
28630		Treat toe dislocation	AAOS, APMA
28635		Treat toe dislocation	AAOS, APMA
28636		Treat toe dislocation	AAOS, APMA
28660		Treat toe dislocation	AAOS, APMA
28665		Treat toe dislocation	AAOS, APMA
28666		Treat toe dislocation	AAOS, APMA
30000		Drainage of nose lesion	AAO-HNS
30020		Drainage of nose lesion	AAO-HNS
30100		Intranasal biopsy	AAO-HNS
30100		Intranasal biopsy	AAO-HNS
30110		Removal of nose polyp(s)	AAO-HNS
30200		Injection treatment of nose	AAO-HNS
30210		Nasal sinus therapy	AAO-HNS
30220		Insert nasal septal button	AAO-HNS
30300		Remove nasal foreign body	AAO-HNS
30310		Remove nasal foreign body	AAO-HNS
30560		Release of nasal adhesions	AAO-HNS
30930		Therapy, fracture of nose	AAO-HNS
31000		Irrigation, maxillary sinus	AAO-HNS
31002		Irrigation, sphenoid sinus	AAO-HNS
31231		Nasal endoscopy, dx	
31233		Nasal/sinus endoscopy, dx	
31235		Nasal/sinus endoscopy, dx	
31237		Nasal/sinus endoscopy, surg	AAO-HNS
31238		Nasal/sinus endoscopy, surg	AAO-HNS
31239		Nasal/sinus endoscopy, surg	AAO-HNS
31240		Nasal/sinus endoscopy, surg	AAO-HNS
31254		Revision of ethmoid sinus	AAO-HNS

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 2 of 10

<i>CPT Code Refinement *</i>	<i>Global Specialty(s) Involved</i>	<i>Descriptor</i>	<i>Extent of</i>
31255		Removal of ethmoid sinus	AAO-HNS
31256		Exploration maxillary sinus	AAO-HNS
31267		Endoscopy, maxillary sinus	AAO-HNS
31276		Sinus endoscopy, surgical	AAO-HNS
31287		Nasal/sinus endoscopy, surg	AAO-HNS
31288		Nasal/sinus endoscopy, surg	AAO-HNS
31290		Nasal/sinus endoscopy, surg	AAO-HNS
31291		Nasal/sinus endoscopy, surg	AAO-HNS
31292		Nasal/sinus endoscopy, surg	AAO-HNS
31293		Nasal/sinus endoscopy, surg	AAO-HNS
31294		Nasal/sinus endoscopy, surg	AAO-HNS
31505		Diagnostic laryngoscopy	AAO-HNS
31510		Laryngoscopy with biopsy	AAO-HNS
31511		Remove foreign body, larynx	AAO-HNS
31512		Removal of larynx lesion	AAO-HNS
31513		Injection into vocal cord	AAO-HNS
31515		Laryngoscopy for aspiration	AAO-HNS
31520		Diagnostic laryngoscopy	AAO-HNS
31525		Diagnostic laryngoscopy	AAO-HNS
31526		Diagnostic laryngoscopy	AAO-HNS
31527		Laryngoscopy for treatment	AAO-HNS
31528		Laryngoscopy and dilation	AAO-HNS
31529		Laryngoscopy and dilation	AAO-HNS
31530		Operative laryngoscopy	AAO-HNS
31531		Operative laryngoscopy	AAO-HNS
31535		Operative laryngoscopy	AAO-HNS
31536		Operative laryngoscopy	AAO-HNS
31540		Operative laryngoscopy	AAO-HNS
31541		Operative laryngoscopy	AAO-HNS
31560		Operative laryngoscopy	AAO-HNS
31561		Operative laryngoscopy	AAO-HNS
31570		Laryngoscopy with injection	AAO-HNS
31571		Laryngoscopy with injection	AAO-HNS
31575		Diagnostic laryngoscopy	AAO-HNS
31576		Laryngoscopy with biopsy	AAO-HNS
31577		Remove foreign body, larynx	AAO-HNS
31578		Removal of larynx lesion	AAO-HNS
31579		Diagnostic laryngoscopy	AAO-HNS
31600		Incision of windpipe	ACS, ASGS, AAO-HNS
31601		Incision of windpipe	AAO-HNS
31603		Incision of windpipe	ACS, ASGS, AAO-HNS
31605		Incision of windpipe	ACS, ASGS, AAO-HNS
31612		Puncture/clear windpipe	AAO-HNS
31615		Visualization of windpipe	AAO-HNS
32601		Thoracoscopy, diagnostic	ACS, ASGS
32602		Thoracoscopy, diagnostic	ACS, ASGS
32603		Thoracoscopy, diagnostic	
32604		Thoracoscopy, diagnostic	
32605		Thoracoscopy, diagnostic	
32606		Thoracoscopy, diagnostic	ACS, ASGS
36640		Insertion catheter, artery	ACS, ASGS
36680		Insert needle, bone cavity	AAOS
36810		Insertion of cannula	ACS, ASGS
36815		Insertion of cannula	ACS, ASGS
37202		Transcatheter therapy infuse	AAOS
		Clinical Labor Only	

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 3 of 10

<i>CPT Code</i>	<i>Global Specialty(s) Involved</i>	<i>Descriptor</i>	<i>Extent of</i>
37207		Transcatheter stent	ACS
37609		Temporal artery procedure	ACS, ASGS
38300		Drainage, lymph node lesion	ACS, ASGS
38500		Biopsy/removal, lymph nodes	ACS, ASGS, AAO-HNS
38505		Needle biopsy, lymph nodes	ASGS, AAO-HNS, ACR,
ACS			
38505		Needle biopsy, lymph nodes	ASGS, AAO-HNS, ACR,
ACS			
38510		Biopsy/removal, lymph nodes	ACS, ASGS, AAO-HNS
38570		Laparoscopy, lymph node biop	ACS, ASGS, ACOG
38571		Laparoscopy, lymphadenectomy	ACOG
38572		Laparoscopy, lymphadenectomy	ACOG
38790		Inject for lymphatic x-ray	ACS, ASGS
38792		Identify sentinel node	ACS, ASGS
41000		Drainage of mouth lesion	AAO-HNS
41252		Repair tongue laceration	AAO-HNS
42000		Drainage mouth roof lesion	AAO-HNS
42100		Biopsy roof of mouth	AAO-HNS
42104		Excision lesion, mouth roof	AAO-HNS
42180		Repair palate	AAO-HNS
42182		Repair palate	AAO-HNS
42281		Insertion, palate prosthesis	AAO-HNS
42300		Drainage of salivary gland	AAO-HNS
42310		Drainage of salivary gland	AAO-HNS
42320		Drainage of salivary gland	AAO-HNS
42330		Removal of salivary stone	AAO-HNS
42400		Biopsy of salivary gland	AAO-HNS
42400		Biopsy of salivary gland	AAO-HNS
42405		Biopsy of salivary gland	AAO-HNS
42650		Dilation of salivary duct	AAO-HNS
42660		Dilation of salivary duct	AAO-HNS
42700		Drainage of tonsil abscess	AAO-HNS
42720		Drainage of throat abscess	AAO-HNS
42800		Biopsy of throat	AAO-HNS
42802		Biopsy of throat	AAO-HNS
42804		Biopsy of upper nose/throat	AAO-HNS
42806		Biopsy of upper nose/throat	AAO-HNS
42808		Excise pharynx lesion	AAO-HNS
42809		Remove pharynx foreign body	AAO-HNS
42900		Repair throat wound	AAO-HNS
42960		Control throat bleeding	AAO-HNS
43200		Esophagus endoscopy	ASGE, AAO-HNS
43202		Esophagus endoscopy, biopsy	ASGE, AAO-HNS
43204		Esophagus endoscopy & inject	ASGE
43205		Esophagus endoscopy/ligation	ASGE
43215		Esophagus endoscopy	ASGE
43217		Esophagus endoscopy	ASGE
43219		Esophagus endoscopy	ASGE
43220		Esoph endoscopy, dilation	ASGE
43226		Esoph endoscopy, dilation	ASGE
43227		Esoph endoscopy, repair	ASGE
43228		Esoph endoscopy, ablation	ASGE
43231		Esoph endoscopy w/us exam	ASGE
43232		Esoph endoscopy w/us fn bx	ASGE
43234		Upper GI endoscopy, exam	ACS, ASGE
43260		Endo cholangiopancreatograph	ASGE
43261		Endo cholangiopancreatograph	ASGE

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 4 of 10

CPT Code Refinement *	Global Specialty(s) Involved	Descriptor	Extent of
43262	Endo cholangiopancreatograph		ASGE
43263	Endo cholangiopancreatograph		ASGE
43264	Endo cholangiopancreatograph		ASGE
43265	Endo cholangiopancreatograph		ASGE
43267	Endo cholangiopancreatograph		ASGE
43268	Endo cholangiopancreatograph		ASGE
43269	Endo cholangiopancreatograph		ASGE
43271	Endo cholangiopancreatograph		ASGE
43272	Endo cholangiopancreatograph		ASGE
44360	Small bowel endoscopy		ASGE
44361	Small bowel endoscopy/biopsy		ASGE
44363	Small bowel endoscopy		ASGE
44364	Small bowel endoscopy		ASGE
44365	Small bowel endoscopy		ASGE
44366	Small bowel endoscopy		ASGE
44369	Small bowel endoscopy		ASGE
44370	Small bowel endoscopy/stent		ASGE, ACS
44372	Small bowel endoscopy		ASGE
44373	Small bowel endoscopy		ASGE
44373	Small bowel endoscopy		ASGE
44376	Small bowel endoscopy		ASGE
44377	Small bowel endoscopy/biopsy		ASGE
44377	Small bowel endoscopy/biopsy		ASGE
44378	Small bowel endoscopy		ASGE
44379	S bowel endoscope w/stent		PEAC
44379	S bowel endoscope w/stent		PEAC
44380	Small bowel endoscopy		ASGE
44382	Small bowel endoscopy		ASGE
44382	Small bowel endoscopy		ASGE
44383	Ileoscopy w/stent		ASCRoS, ASGE, ACS
44388	Colon endoscopy		ASCRoS, ASGE, ACS
44388	Colon endoscopy		ASCRoS, ASGE, ACS
44389	Colonoscopy with biopsy		ASCRoS, ASGE
44390	Colonoscopy for foreign body		ASCRoS, ASGE
44390	Colonoscopy for foreign body		ASCRoS, ASGE
44391	Colonoscopy for bleeding		ASCRoS, ASGE
44392	Colonoscopy & polypectomy		ASCRoS, ASGE, ACS
44392	Colonoscopy & polypectomy		ASCRoS, ASGE, ACS
44393	Colonoscopy, lesion removal		ASCRoS, ASGE
44394	Colonoscopy w/snare		ASCRoS, ASGE
44394	Colonoscopy w/snare		ASCRoS, ASGE
44397	Colonoscopy w stent		ASCRoS, ASGE, ACS
45300	Proctosigmoidoscopy dx		ASCRoS, ACS
45303	Proctosigmoidoscopy dilate		ASCRoS, ACS
45305	Proctosigmoidoscopy w/bx		ASCRoS, ACS
45307	Proctosigmoidoscopy fb		ASCRoS, ACS
45308	Proctosigmoidoscopy removal		ASCRoS, ACS
45309	Proctosigmoidoscopy removal		ASCRoS, ACS
45315	Proctosigmoidoscopy removal		ASCRoS, ACS
45317	Proctosigmoidoscopy bleed		ASCRoS, ACS
45320	Proctosigmoidoscopy ablate		ASCRoS, ACS
45321	Proctosigmoidoscopy volvul		ASCRoS, ACS
45327	Proctosigmoidoscopy w/stent		ASCRoS, ACS
45355	Surgical colonoscopy		ASCRoS, ASGE, ACS
45387	Colonoscopy w/stent		ASCRoS, ASGE

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 5 of 10

CPT Code Refinement *	Global Specialty(s) Involved	Descriptor	Extent of
45900	Reduction of rectal prolapse		ACS, ASGS, ASCRoS
45905	Dilation of anal sphincter		ACS, ASGS, ASCRoS
45910	Dilation of rectal narrowing		ACS, ASGS, ASCRoS
46030	Removal of rectal marker		ACS, ASGS, ASCRoS
46050	Incision of anal abscess		ACS, ASGS, ASCRoS
46080	Incision of anal sphincter		ACS, ASGS, ASCRoS
46083	Incise external hemorrhoid		ACS, ASGS, ASCRoS
46220	Removal of anal tab		ACS, ASGS, ASCRoS
46230	Removal of anal tabs		ACS, ASGS, ASCRoS
46320	Removal of hemorrhoid clot		ACS, ASGS, ASCRoS
46600	Diagnostic anoscopy		ASCRoS, ACS
46604	Anoscopy and dilation		ASCRoS, ACS
46606	Anoscopy and biopsy		ASCRoS, ACS
46608	Anoscopy/ remove for body		ASCRoS, ACS
46610	Anoscopy/remove lesion		ASCRoS, ACS
46611	Anoscopy		ASCRoS, ACS
46612	Anoscopy/ remove lesions		ASCRoS, ACS
46614	Anoscopy/control bleeding		ASCRoS, ACS
46615	Anoscopy		ASCRoS, ACS
46754	Removal of suture from anus		ACS, ASGS, ASCRoS
46910	Destruction, anal lesion(s)		ACS, ASGS, ASCRoS
46916	Cryosurgery, anal lesion(s)		ACS, ASGS, ASCRoS
46917	Laser surgery, anal lesions		ACS, ASGS, ASCRoS
46922	Excision of anal lesion(s)		ACS, ASGS, ASCRoS
46924	Destruction, anal lesion(s)		ACS, ASGS, ASCRoS
46935	Destruction of hemorrhoids		ACS, ASGS, ASCRoS
46937	Cryotherapy of rectal lesion		ACS, ASGS, ASCRoS
46940	Treatment of anal fissure		ACS, ASGS, ASCRoS
46942	Treatment of anal fissure		ACS, ASGS, ASCRoS
47382	Percut ablate liver rf		ACS, ASGS
47552	Biliary endoscopy thru skin		ASGS, ACS
47554	Biliary endoscopy thru skin		ASGS, ACS
49320	Diag laparo separate proc		ACS, ASGS, ACOG
49320	Diag laparo separate proc		ACS, ASGS, ACOG
49321	Laparoscopy, biopsy		ACS, ASGS, ACOG
49321	Laparoscopy, biopsy		ACS, ASGS, ACOG
49322	Laparoscopy, aspiration		ACS, ASGS, ACOG
49322	Laparoscopy, aspiration		ACS, ASGS, ACOG
49420	Insert abdominal drain		ASGS, ACS
49422	Remove perm cannula/catheter		ACS, ASGS
49429	Removal of shunt		ACS, ASGS
50021	Renal abscess, percut drain		AUA
51605	Preparation for bladder xray		AUA
51610	Injection for bladder x-ray		AUA
51710	Change of bladder tube		AUA
51715	Endoscopic injection/implant		AUA
51725	Simple cystometrogram		
51726	Complex cystometrogram		
51736	Urine flow measurement		
51741	Electro-uroflowmetry, first		
51772	Urethra pressure profile		
51784	Anal/urinary muscle study		
51785	Anal/urinary muscle study		
51792	Urinary reflex study		
51795	Urine voiding pressure study		

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 6 of 10

<i>CPT Code</i>	<i>Global</i>	<i>Descriptor</i>	<i>Extent of</i>
<i>Refinement *</i>	<i>Specialty(s) Involved</i>		
51797		Intraabdominal pressure test	
52001		Cystoscopy, removal of clots	AUA
52005		Cystoscopy & ureter catheter	AUA
52204		Cystoscopy	AUA
52214		Cystoscopy and treatment	AUA
52224		Cystoscopy and treatment	AUA
52234		Cystoscopy and treatment	AUA
52235		Cystoscopy and treatment	AUA
52240		Cystoscopy and treatment	AUA
52260		Cystoscopy and treatment	AUA
52265		Cystoscopy and treatment	AUA
52270		Cystoscopy & revise urethra	AUA
52275		Cystoscopy & revise urethra	AUA
52276		Cystoscopy and treatment	AUA
52315		Cystoscopy and treatment	AUA
52317		Remove bladder stone	AUA
52318		Remove bladder stone	AUA
52320		Cystoscopy and treatment	AUA
52325		Cystoscopy, stone removal	AUA
52327		Cystoscopy, inject material	AUA
52330		Cystoscopy and treatment	AUA
52332		Cystoscopy and treatment	AUA
52400		Cystouretero w/congen repr	
52450		Incision of prostate	
52500		Revision of bladder neck	
52510		Dilation prostatic urethra	
52601		Prostatectomy (TURP)	
52606		Control postop bleeding	
52612		Prostatectomy, first stage	
52614		Prostatectomy, second stage	
52620		Remove residual prostate	
52630		Remove prostate regrowth	
52640		Relieve bladder contracture	
52647		Laser surgery of prostate	
52648		Laser surgery of prostate	
52700		Drainage of prostate abscess	
53000		Incision of urethra	AUA
53020		Incision of urethra	AUA
53025		Incision of urethra	AUA
53060		Drainage of urethra abscess	AUA
53200		Biopsy of urethra	AUA
53260		Treatment of urethra lesion	AUA
53265		Treatment of urethra lesion	AUA
53270		Removal of urethra gland	AUA
53275		Repair of urethra defect	AUA
54000		Slitting of prepuce	AUA
54001		Slitting of prepuce	AUA
54015		Drain penis lesion	AUA
54050		Destruction, penis lesion(s)	AUA
54055		Destruction, penis lesion(s)	AUA
54056		Cryosurgery, penis lesion(s)	AUA
54057		Laser surg, penis lesion(s)	AUA
54060		Excision of penis lesion(s)	AUA
54065		Destruction, penis lesion(s)	AUA
54100		Biopsy of penis	AUA

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 7 of 10

<i>CPT Code Refinement *</i>	<i>Global Specialty(s) Involved</i>	<i>Descriptor</i>	<i>Extent of</i>
54105		Biopsy of penis	AUA
54150		Circumcision	AUA, AAFP
54152		Circumcision	AUA
54160		Circumcision	AUA, AAFP
54161		Circumcision	AUA
54200		Treatment of penis lesion	AUA
54220		Treatment of penis lesion	AUA
54230		Prepare penis study	AUA
54231		Dynamic cavernosometry	AUA
54235		Penile injection	AUA
54240		Penis study	AUA
54250		Penis study	AUA
54500		Biopsy of testis	AUA
54505		Biopsy of testis	AUA
54620		Suspension of testis	AUA
54700		Drainage of scrotum	AUA
54800		Biopsy of epididymis	AUA
55000		Drainage of hydrocele	AUA
55100		Drainage of scrotum abscess	AUA
55300		Prepare, sperm duct x-ray	AUA
55450		Ligation of sperm duct	AUA
55705		Biopsy of prostate	AUA
55870		Electroejaculation	AUA
56405		I & D of vulva/perineum	ACOG
56440		Surgery for vulva lesion	ACOG
56441		Lysis of labial lesion(s)	ACOG
56501		Destroy, vulva lesions, simp	ACOG, AAFP
56515		Destroy vulva lesion/s compl	ACOG, AAFP
56800		Repair of vagina	ACOG
56810		Repair of perineum	ACOG
57000		Exploration of vagina	ACOG
57020		Drainage of pelvic fluid	ACOG
57022		I & d vaginal hematoma, pp	ACOG
57023		I & d vag hematoma, non-ob	ACOG
57061		Destroy vag lesions, simple	ACOG
57065		Destroy vag lesions, complex	ACOG
57135		Remove vagina lesion	ACOG
57410		Pelvic examination	ACOG
57415		Remove vaginal foreign body	ACOG
57505		Endocervical curettage	ACOG, AAFP
57510		Cauterization of cervix	ACOG, AAFP
57511		Cryocautery of cervix	ACOG, AAFP
57513		Laser surgery of cervix	ACOG
58301		Remove intrauterine device	ACOG
58321		Artificial insemination	ACOG
58322		Artificial insemination	ACOG
58340		Catheter for hystero-graphy	ACOG
58345		Reopen fallopian tube	ACOG, ACR
58350		Reopen fallopian tube	ACOG
58353		Endometr ablate, thermal	ACOG
58615		Occlude fallopian tube(s)	ACOG
58661		Laparoscopy, remove adnexa	ACOG
58661		Laparoscopy, remove adnexa	ACOG
58970		Retrieval of oocyte	ACOG
58974		Transfer of embryo	ACOG

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 8 of 10

<i>CPT Code</i>	<i>Global</i>	<i>Descriptor</i>	<i>Extent of</i>
<i>Refinement *</i>	<i>Specialty(s) Involved</i>		
58976	Transfer of embryo		ACOG
59001	Amniocentesis, therapeutic		ACOG
59001	Amniocentesis, therapeutic		ACOG
59020	Fetal contract stress test		ACOG
59025	Fetal non-stress test		ACOG
59200	Insert cervical dilator		ACOG
59840	Abortion		ACOG
59841	Abortion		ACOG
59866	Abortion (mpr)		ACOG
59871	Remove cerclage suture		ACOG
62263	Lysis epidural adhesions		NASS, AAPM&R
62268	Drain spinal cord cyst		NASS, AAPM&R
62269	Needle biopsy, spinal cord		NASS, AAPM&R
63610	Stimulation of spinal cord		NASS
64553	Implant neuroelectrodes		NASS, AAPM&R
64555	Implant neuroelectrodes		NASS, AAPM&R
64560	Implant neuroelectrodes		NASS, AAPM&R
64561	Implant neuroelectrodes		NASS, AAPM&R
64565	Implant neuroelectrodes		NASS, AAPM&R
64585	Revise/remove neuroelectrode		NASS, AAPM&R
64590	Implant neuroreceiver		NASS, AAPM&R
64595	Revise/remove neuroreceiver		NASS, AAPM&R
64795	Biopsy of nerve		ASGS, ACS
69000	Drain external ear lesion		AAO-HNS
69005	Drain external ear lesion		AAO-HNS
69020	Drain outer ear canal lesion		AAO-HNS
69105	Biopsy of external ear canal		AAO-HNS
69105	Biopsy of external ear canal		AAO-HNS
69200	Clear outer ear canal		AAO-HNS
69205	Clear outer ear canal		AAO-HNS
69220	Clean out mastoid cavity		AAO-HNS
69222	Clean out mastoid cavity		AAO-HNS
69400	Inflate middle ear canal		AAO-HNS
69401	Inflate middle ear canal		AAO-HNS
69405	Catheterize middle ear canal		AAO-HNS
69410	Inset middle ear (baffle)		AAO-HNS
69420	Incision of eardrum		AAO-HNS
69421	Incision of eardrum		AAO-HNS
69424	Remove ventilating tube		AAO-HNS
69433	Create eardrum opening		AAO-HNS
69436	Create eardrum opening		AAO-HNS
69540	Remove ear lesion		AAO-HNS
69610	Repair of eardrum		AAO-HNS
92502	Ear and throat examination		
92960	Cardioversion electric, ext		ACC
92961	Cardioversion, electric, int		ACC
93600	Bundle of His recording		ACC
93602	Intra-atrial recording		ACC
93603	Right ventricular recording		ACC
93610	Intra-atrial pacing		ACC
93612	Intraventricular pacing		ACC
93615	Esophageal recording		ACC
93616	Esophageal recording		ACC
93618	Heart rhythm pacing		ACC
93619	Electrophysiology evaluation		ACC

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 9 of 10

<i>CPT Code</i>	<i>Global</i>	<i>Descriptor</i>	<i>Extent of</i>
<i>Refinement *</i>	<i>Specialty(s) Involved</i>		
93620	Electrophysiology evaluation		ACC
93621	Electrophysiology evaluation		
93622	Electrophysiology evaluation		
93623	Stimulation, pacing heart		
93624	Electrophysiologic study		ACC
93631	Heart pacing, mapping		ACC
93640	Evaluation heart device		ACC
93641	Electrophysiology evaluation		ACC
93642	Electrophysiology evaluation		ACC
93650	Ablate heart dysrhythm focus		ACC
93651	Ablate heart dysrhythm focus		ACC
93652	Ablate heart dysrhythm focus		ACC

** Where the extent of refinement is blank, all PE direct inputs were refined.*

10 of 10

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

March 20-21, 2003

Ann Cea, MD (Chair)	James Metcalf, MD
James Anthony, MD	Tye Ouzounian, MD
Katherine Bradley, PhD, RN	Julia Pillsbury, DO
Manuel D. Cerqueira, MD	Dighton Packard, MD
Neal Cohen, MD	Jordan Pritzker, MD*
Thomas A. Felger, MD	James Regan, MD
Blair Filler, MD	Anthony Senagore, MD
Mary Foto, OTR	Ronald Shellow, MD
David Hoak, MD*	Daniel Mark Siegel, MD, MS
Keith Horvath*	Robert Stomel, DO
Rebecca Johnson, MD*	Charles Weissman, MD
Gregory Kwasny, MD	Richard Whitten*
Peter McCreight, MD	Lester Wold, MD
Scott Manaker, MD	

* Alternate PEAC Member

Election of Rotating Seats

The PEAC held an election for the two internal medicine rotating seats and the “any other” specialty seat. The PEAC elected Charles Shoemaker, MD, American Society of General Surgeons (ASGS) to the “any other” seat and Joel Brill, MD American Gastroenterological Association (AGA) and Richard Dickey, MD The Endocrine Society (TES) to the internal medicine seats. These terms will begin at the conclusion of the March meeting. The PEAC expressed its gratitude to the following physicians who currently hold the rotating PEAC seats for their service since 1999: Ronald Kaufman, MD, American College of Rheumatology, Susan Spires, MD, American Society of Cytopathology, and Charles Weissman, MD, American Society of Clinical Oncology.

PEAC Process Issues

I. Codes not included in the level of interest process

Specialty societies submitted approximately 26 codes for the March PEAC meeting not previously identified through the level of interest process. For these codes, specialty societies refined the inputs for these codes without informing the PEAC that these codes would be on the March agenda. Therefore, these codes did not go through the level of interest process where all specialties had an opportunity to express an interest in refining these codes. Two PEAC members stated that when their specialties began developing

inputs for codes, they discovered that they had omitted some codes in the family and to prevent rank order anomalies, they decided to refine all codes in the family.

Included in this list of 000 and 10 day global period codes are codes that specialty societies did not previously identify as possibly having pre-service time. Because the PEAC has limited the application of the standard pre-service time to only those codes previously identified and listed in PEAC agendas books, the PEAC discussed making an exception to its rule. The PEAC concluded that although these codes did not go through the level of interest process, the PEAC would allow specialties to present these codes at the March 2003 meeting because it appeared that these codes were overlooked previously and should be refined to prevent rank order anomalies within code families.

II. Recommendations that were not submitted

Specialty societies also identified 33 codes through the level of interest process that were placed on the March agenda, but they did not submit any recommendations for these codes. These codes had previously received a PEAC recommendation for pre-service time, and specialties requested that these codes be reviewed again for possible application of the 000 and 10 day global period standard. The PEAC had agreed to reexamine any 000 and 10 day global period code for the pre-service standard but the refinement must take place by March, 2003. This recommendation was originally approved by the PEAC in August 2001 and amended in September, 2002 as follows:

The PEAC recommends that by the ~~September 2002~~ March, 2003 PEAC meeting, those codes with global periods of 0 and 10 days will receive a PEAC recommendation of zero minutes of pre-service time unless a specialty recommends otherwise and is able to provide sufficient data to the PEAC to justify the recommended times.

For new and revised codes where the pre-time had previously been zero, specialties should assume a standard of zero minutes, but should have the opportunity to present pre-time if they can provide acceptable rationale.

A number of PEAC members were concerned about making an exception to its previous recommendation since the deadline had already been extended to March, 2003. Since the PEAC never required specialties to bring these codes back, the PEAC agreed that the previous PEAC recommendation for these codes would remain. These codes would not be brought back for additional pre-service refinement since the due date was not met. The PEAC approved the following motion:

000 and 10 day global period codes that had been previously reviewed by the PEAC but were eligible for the pre-service standard, should retain their previously PEAC refined pre-service times.

III. Review of specific inputs

The codes placed on the March PEAC agenda were identified using a variety of criteria. For example, a large number of 000 and 10 day codes with previously approved pre-service time, were brought back to the PEAC for application of the new pre-service standard time. The PEAC instructed specialties to only refine the pre-service time for these codes but a number of codes were brought back for refinement of all inputs. The PEAC agreed to allow specialties to present these additional inputs at this meeting since it allows specialties to ensure that code families do not have rank order anomalies.

IV. Future Meeting Dates

Doctor Manaker raised the issue of the PEAC's future and asked the PEAC to consider what will happen to refinement after the PEAC concludes in March, 2004. Several options were discussed to involve the PEAC in the review of the direct inputs for new and revised codes. Doctor Manaker asked the PEAC members to think about possible options such as only having one PEAC meeting a year, following the RUC April meeting to review all of the new and revised codes. Doctor Whitten stated that the RUC is beginning to look at this issue and is starting to explore ways to enhance its capabilities to review the direct inputs for new and revised codes.

Scope Cleaning and Surgical Instrument Package Workgroup

Doctor Stomel summarized the finding of the PEAC workgroup which are discussed in detail in the attached workgroup report.

The PEAC approved the following typical scope cleaning times:

- **5 minutes for disposable scope**
- **10 minutes for a rigid scope, and**
- **30 minutes for a flexible scope**

The PEAC discussed how these standards should be implemented, ranging from an automatic application without further review by the PEAC vs. a code by code review. Based on input from CMS, the PEAC agreed that each code that utilizes scopes will need to be examined for application of the cleaning time since there may already be some scope cleaning time included in the direct inputs. In some cases there is only a single

time allocated for room cleaning without specific mention of a scope. Therefore, by the August PEAC meeting, specialties will need to identify those codes needing additional review. The PEAC agreed to apply the standard by informing specialties of the new standard. The PEAC will ask specialties to determine which codes should receive this scope cleaning standard and determine if the time and supplies need to be changed. When a specialty identifies a previously reviewed code, AMA staff will list the currently approved room cleaning time and then allow specialties to determine which type of scope is typically used for those codes since the scope type may vary by specialty.

Surgical Instrument Packages

The workgroup also proposed a standard small and medium surgical instrument package. A large instrument package was not developed since the workgroup felt that such a package is not likely to be used in the office setting. If a specialty felt it needed such a package, it could be presented to the PEAC on a code by code basis. The workgroup felt that use of such a package that would equate to a hospital operating room package is highly unlikely.

Since the actual instruments used vary among specialties, the workgroup focused on the dollar amount for the two packages and recommended the following:

- Basic Surgical Instrument Package - \$500
- Medium Surgical Instrument Package - \$1,500

Although it was recognized that the composition of the packs are somewhat artificial, (see attached workgroup report for itemization) the PEAC felt it was important to recognize these approximate equipment costs and the associated cleaning times. The PEAC concluded that while the specific instruments listed may not apply to all specialties, the total dollar amount assigned to the package would be the same for all specialties. Some workgroup members were concerned that the prices associated with some of the equipment items may be high. The PEAC recognized that the package contents may only apply to Dermatology, but the workgroup was comfortable with the final costs for the packages.

The workgroup also recommended that whenever a package is listed the following cleaning times should be applied.

- **Basic Surgical Instrument Package – 10 minutes**
- **Medium Surgical Instrument Package – 15 minutes**

The PEAC discussed how to apply these standards and differentiated between the small and medium pack. The PEAC felt that the basic instrument package should be applied without much scrutiny since any office surgical procedure would involve a small package and the associated cleaning time. However, for the medium pack, codes that receive

these inputs would need to be examined on a code by code basis to ensure there is not duplication with disposable supplies and with existing clinical staff times. For codes with these packs, the presenters would need to justify that the instrument pack is applicable. It was recommended that a close examination between the pack and disposable items would need to occur. A number of PEAC members felt that using these standard packs is more consistent with current medical practice than including disposable packs in the direct input listings. Therefore, the application of this standard would need to be on a code by code basis as specialties bring codes forward. The application of these standards will be effected by informing specialties of the existence of the standard and allowing specialties to bring codes to the PEAC for application of these standard packages and times on a code by code basis.

The PEAC approved the following:

- **5 minutes of clinical staff time for setting up scopes in the office setting.**
- **Basic Surgical Instrument Package - \$500 and cleaning time of 10 minutes**
- **Medium Surgical Instrument Package - \$1,500 and cleaning time of 15 minutes.**
- **Cleaning supplies for scopes and instrument packages. (These are listed in the attached report)**

Carolyn Mullen stated that if CMS approves the PEAC recommendation for these packages, CMS would most likely remove the existing CMS minor surgical pack and minor equipment pack from the equipment lists and replace them with the new PEAC packages.

CMS Update

Carolyn Mullen reminded the PEAC that CMS is in the process of applying the standard packages to the 90 day global codes. Ms. Mullen explained that the original CPEP data may have contained some specialty-specific supply items but these items would be replaced with the standard packages. In some cases the supplies may be appropriate but since specialties have not asked for any exceptions to standard, CMS has no way of retaining these items. The PEAC discussed this and determined that specialties have known about the standards for two years and have had opportunities to refine the data. Doctor Ouzounian stated that AAOS was aware of the recommendation and in the interest of efficiency and by maintaining the previously agreed upon deadlines, orthopedics has accepted the compromise of the standard packages. There was no opposition expressed to the previously agreed upon rule of applying the standard packages for the 90 day codes.

For the equipment included in the conscious sedation package, CMS requested clarification to determine the equipment utilization times. The PEAC clarified that the

cardio-respiratory monitor, the pulse oximeter, and oxygen tank are used throughout the entire encounter including recover time, and the infusion pump is used only during the procedure.

PEAC E/M Workgroup

Doctor Shellow presented the report of the PEAC E/M, which is attached to these minutes. Each code family was reviewed and voted on separately. The PEAC discussed whether the inpatient consultation codes would have some time attributed for phone calls among office nursing staff and hospital staff. While such phone calls may occur for some specialties, the PEAC was not comfortable allocating the time since it was not a typical occurrence. The PEAC examined each code family and approved the recommendations from the E/M workgroup. See the attached workgroup report.

In-Office Percutaneous Endovascular Procedures

A pre-facilitation committee, chaired by Doctor Cerqueira had some difficulty in evaluating the percutaneous endovascular codes presented by SIR and ACR. Doctor Cerqueira explained that there is no precedent or guidelines for establishing practice expense input recommendations for procedures once performed only in facility, but with new technology these same procedures are performed in the office. The pre-facilitation committee recommended that a workgroup be formed to address this issue. The Workgroup members would include: Doctors Cerqueira (Chair), Cohen, Felger, McCreight, Regan, Stomel and Katherine Bradley, PhD, RN as well as Doctor Ken Simon, CMS.

The PEAC discussed the pre-facilitation committee's recommendation. The PEAC raised several issues regarding the practice expense inputs for these codes. The most significant issue raised was with this new ability to perform these in-facility procedures in an office setting, will CMS create a comparable shift of funds from the Part A budget to the Part B budget to compensate for the shift in practice. CMS representatives agreed that this is a serious issue that they have currently been asked to address by industry and various physician associations, however, currently they are unsure if CMS will be able to make this shift in the budgets. A number of PEAC members were not in favor of having the PEAC workgroup even meet until the funding issue is resolved.

The PEAC discussed bringing the practice expense issues related to the in-office procedures to the full RUC for review. AMA staff informed the PEAC that the April RUC meeting will be having a New Technology Session where Tom Scully, Director of CMS will be present. Because it is new technology that has allowed for this shift in the site of service within these procedures, AMA staff recommended that this issue be addressed at this session, recognizing that this is not specifically a PEAC issue. In addition, several members of the In-Office Percutaneous Endovascular Procedures Workgroup expressed an interest in attending the RUC meeting. It was suggested by several workgroup members that a PEAC representative be able to join in the discussion to provide a PEAC perspective on this issue.

To prepare for the New Technology Session in April, the PEAC recommended that the Workgroup members should participate in a conference call to identify practice expense policy issues and questions that would pertain to the current shift of procedures traditionally being performed in a facility setting now being performed in an office setting.

The PEAC reviewed the recommendations originally presented to the pre-facilitation committee and decided to refine the pre-service times. Since most of the codes brought forward are 000 day global period codes with pre-service times that were not previously reviewed by the PEAC, the PEAC decided to refine the pre-service time for these codes to prevent the pre-service times from going to zero. The PEAC did not attempt to refine the other inputs because of the issues involved in performing the procedures in the office setting and since the presenters were not present. The PEAC did agree to allow the codes to be refined in August. The PEAC passed the following motion:

All codes in Tab 11 that currently have pre-service time in the CPEP database, are recommended to have out-of-office clinical labor pre-service time of :

5 minutes to complete pre-service diagnostic & referral forms

10 minutes to coordinate pre-surgery services

5 minutes to schedule space and equipment in the facility

And

3 minutes of post-service time for conducting phone calls/call in prescriptions

In addition, these codes may be revisited at the August 2003 PEAC meeting, with the caveat that only one set of recommendations will be presented and that the following specialty societies are in agreement with that recommendation: cardio vascular surgery, vascular surgery, and interventional radiology.

This resulted in the following applications of time:

The PEAC recommended that the following codes out of office practice expense inputs should consist of a total clinical labor time (RN/LPN/MTA) of 23 minutes:

35450	35454
35452	35456
35458	36481
35459	32201
35460	44901
35480	48511
35481	49041
35482	49061
35483	35470
35484	35471
35485	35472

Approved at the April 2003 RUC Meeting

35473	37203
35473	49021
35474	47525
35475	47530
35476	50021
58823	

**AMA/Specialty Society RVS Update Committee
Practice Expense Advisory Committee
PEAC Workgroup on Scope Cleaning and Surgical Instrument Packages
Minutes of Conference Call March 11, 2003**

The following members of the workgroup participated in the call: Doctors Robert Stomel (chair), Deborah Bash, Tom Felger, Jordan Pritzker, and Daniel Siegel.

The workgroup met to discuss and decide on the following four issues:

- finalize the scope cleaning times and activities
- determine if a standard scope set up time was needed
- develop standard instrument packages
- finalize the cleaning times for the instrument packages

Scope Cleaning and Other Activities

The workgroup revisited the time spend by clinical labor staff to clean and sterilize the three typical types of scopes used for clinical examinations. Members of the group agreed that typically for the non disposable parts, such as the eye piece, of a disposable scope required 5 minutes of cleaning time. In addition, rigid scopes required typically 10 minutes, and a flexible scope required 30 minutes of cleaning time. The workgroup believed that overall the flexible scope required the most time and intensity to clean and sterilize. 30 minutes of cleaning time was based partly on a time an motion study for transesophageal scope disinfection procedures outlined by the chair of the workgroup, and from the workgroup members experience. The workgroup believed that in some specialties and practices the cleaning times would vary, however **the typical average time for scope cleaning could be categorized and is recommended to the PEAC as follows:**

- **5 minutes for disposable scope**
- **10 minutes for a rigid scope, and**
- **30 minutes for a flexible scope**

The workgroup also recognized that regardless of the type of scope, additional time was required to set up the scope for the procedure. Again, members of the workgroup understood that for some specialties and practices the set up time would vary, however the workgroup agreed that a standard set up time of 5 minutes would be appropriate. In addition, five minutes was accepted as a typical time accepted by the PEAC at its meeting in January 2003 for several otolarygologic procedures. A separate line item on the PEAC spreadsheet should be added to delineate this additional time. **The workgroup recommends to the PEAC that 5 minutes be the standard time for setting up scopes in the office setting.**

Surgical Instrument Packages and Cleaning

The workgroup concentrated on establishing two standard surgical instrument packages. Members of the workgroup believed that a small and medium surgical instrument packages should be developed with an approximate cost. The workgroup understood that each society may have there own set of small and medium surgical instrument packs with different instruments. In fact, some specialties may need 6 instruments for there small instrument package while others may need 8. Regardless of the number of surgical instruments in the small and medium surgical instrument packs, the workgroup researched catalog prices for a these typical packs and believed that the average typical cost for a basic surgical instrument package would cost approximately \$500, and a medium surgical instrument package would cost approximately \$1500. These costs were estimated from the attached examples of typical surgical instrument packages for one specialty. The workgroup understands that this example includes many premium brand instruments. However, like the pricing of the otoscope at \$505, you

Approved at the April 2003 RUC Meeting

may find instruments that cost more or less than this example which meets the \$500 threshold to be identified as direct medical equipment.

Procedures requiring anything larger than a medium package, the specialty would specifically need to identify the additional items and cost. The workgroup members believed that a large surgical instrument package would only be for a few specific procedures.

Workgroup members believed that typically, most procedures would need a basic surgical instrument package and all codes should have one as a practice expense item. Medium surgical instrument packages, however, needed to be justified on a code by code basis and may not be frequently applied. The workgroup believed that a blanket application of the basic surgical instrument package to surgical procedures can be compiled for review, eliminating the PEAC's need to review each specific code. It was pointed out, however, that some of the items in the surgical packages may already be listed as practice expense items for many of the codes in the CPEP data. Workgroup members believed that any duplication of practice expense items would have to be eliminated, noting that the suture removal kit (item 31701) and the current specialty specific surgical instrument package contain similar or identical items. **The workgroup recommends that the PEAC adopt the following surgical instrument packages in their refinement process:**

- **Basic Surgical Instrument Package - \$500**
- **Medium Surgical Instrument Package - \$1,500**

The workgroup recommends that each specialty identify which of their codes should have the basic instrument package and which should have the medium instrument package. The PEAC will automatically apply the basic surgical instrument package to those codes identified by specialties. The PEAC would review any listing of codes that required either a medium surgical instrument package or a larger specialty specific instrument package. Specialties will also need to identify which supply and equipment items should be deleted as they will now be substituted by these packages. It is proposed that this review can be conducted over the summer of 2003 and reviewed at the August 2003 PEAC meeting.

The process of cleaning the surgical instruments from each package was revisited by the workgroup as well. At its initial conference call, workgroup members agreed to cleaning times of 10 minutes for the basic surgical instrument package, 15 minutes for a medium package, and 20 minutes for a large package. Members of the workgroup continued to support this breakdown of time, but agreed that the time for the large package should be dropped, and specialties would need to justify the time according to their specific large surgical instrument package. The workgroup agreed and recommends to the PEAC the following cleaning times for surgical instrument packages:

- **Basic Surgical Instrument Package – 10 minutes**
- **Medium Surgical Instrument Package – 15 minutes**

Workgroup members noted earlier that the cleaning times do not increase in a linear manner as the size of the package increases since there is a certain amount of fixed base time needed regardless of the package size.

Cleaning Supplies – Scopes and Instruments

The workgroup discussed the typical cleaning supplies necessary for scopes and surgical instruments. Supplies for scopes are outlined in the scope cleaning and instrument packages for transesophageal scope disinfection procedure attached to these minutes. In addition, AAO-HNS developed a list of cleaning supplies typically used for nasal endoscopy at the January 2003 PEAC meeting. Additional

Approved at the April 2003 RUC Meeting

information is needed for all sets of supplies for scopes and for surgical instrument packages, and the workgroup agreed to supply this information to the PEAC at its meeting in March 2003.

Attached to this report are the following supporting documents:

1. Transesophageal Scope Disinfection Procedures, including supplies necessary
2. Examples of Small and Medium Surgical Instrument Packages

**PEAC WORKGROUP
SCOPE CLEANING & INSTRUMENT PACKAGES**

TRANSESOPHAGEAL SCOPE DISINFECTION PROCEDURE

Supplies:

- 1 bottle – Cidex OPA (or any approved disinfection solution according to manufacturer of scope)
- 2 – Disinfection tub or basin
- 9 – Gauze 4X4
- 4 – Gloves
- 1 – Splash shield
- 1 – Gown
- 2 oz – Isopropyl Alcohol 70%
- 1 – Cidex solution test strips
- Electric leakage tester
- 1 – Endoscope bags (to carry contaminated scope)

Prior to cleaning the scope, the individual is to use proper attire to ensure safety during the decontamination process. This includes wearing gloves, splash shield and gown. Proper hand washing techniques are always necessary. Set up of the procedure includes programming the transesophageal probe with the echo machine (Time – 5 minutes).

1. Rinse contaminated scope with water and wipe with dry gauze.
2. Soak scope in Cidex OPA for no less than 12 minutes and no more than 1 hour.
3. Perform leakage test on scope while in the Cidex to ensure proper equipment condition.
 - a. place machine electrodes in the Cidex solution and push test button to ensure no electricity is emitting from the scope itself into the Cidex bath.
4. Wipe handle and cord of scope with 70% Isopropyl alcohol thoroughly.
5. Rinse scope in a fresh quantity of water. This is done in three separate water baths.
 - b. Use a clean tub full of water to immerse scope (not the handle). The scope must remain in the water bath for 1 minute. Take the scope out, discard the water. Repeat this process two more times. This process ensures no residual Cidex OPA is left on the scope.
6. Visually inspect the scope for damage and/or wearing down of the protective sheath on the scope.
7. Hang the scope to dry.
8. Cidex OPA solution test strips are to be used prior to each cleaning when repetitively using solution. Solution to be changed when it fails the test strips or is two weeks old. This may be subject to change with different disinfection solutions.

Total process time estimated at 30 minutes.

Approximate agreed upon time for flexible scope cleaning is 22 minutes.

10 minutes for rigid scope cleaning.

5 minutes for disposable scope.

BASIC TRAY	PRICE	SOURCE
Webster Needle Holder, Tungsten Carbide, serrated	\$98.00	Delasco.co m
Adson Forceps 4 3/4", 1x2 Teeth with suture tying platform, Tungsten Carbide	\$108.75	Delasco.co m
Gradle Supercut Scissors 3 3/4", Slightly Curved, Sharp/Sharp Tips, Stainless Steel	\$93.50	Delasco.co m
Oliver Suture Applying Scissors (11.5cm) 4 1/2", Sharp/Sharp Tips, Curved, Stainless Steel	\$30.00	Delasco.co m
Hemostat, Micro-mosquito 4 3/4", Curved, Delicate	\$50.50	Delasco.co m
Hemostat, Micro-mosquito 4 3/4", Straight	\$50.50	Delasco.co m
#3 Siegel Round Scalpel Handle 5 3/4" (15.5cm), Knurled Handle	\$26.60	Delasco.co m
Backhaus Towel Clamp 4", Stainless Steel	\$34.50	Delasco.co m
Curette, Buck, Straight 6 1/2", Sharp, Size 3	\$28.90	Delasco.co m
BASIC TRAY TOTAL	\$521.25	

MEDIUM TRAY IN ADDITION TO ABOVE		
Forceps, Bishop Harmon 3 3/8" 1x2 Teeth Fenestrated Handle	\$77.50	Delasco.co m
Chalazion Forceps 3 1/2"(Available in various sizes)	\$99.50	Delasco.co m
Packer Mosquito Hemostat 5", Straight, Flat Jaws	\$73.75	Delasco.co m
Packer Mosquito Hemostat 5", Curved, Serrated, Flat Jaws	\$78.50	Delasco.co m
Bergman Skin Hook 5 1/2", One Sharp Point, 7mm Diameter, Flat Handle	\$29.00	Delasco.co m
Guthrie Skin Hook 4 3/4", 2 Sharp Prongs, 1mm Diameter, 1.5mm Wide	\$66.00	Delasco.co m
Jaeger Lid Plate 4", Blades 20mm and 23mm, Stainless Steel	\$25.10	Delasco.co m
Dual Action Nail Nipper 6", Delicate Straight Jaws, Double Spring, Stainless Steel	\$225.00	Delasco.co m
Retractor, Alm 3"(7.5cm), 4 X 4 Blunt	\$98.75	Delasco.co m
Desmarres Lid Retractor 5 1/2"(14cm), Various sizes	\$47.20	Delasco.co m
Ratchet Retractor 4" (10cm), 4x4 Prongs, Blunt, Cross Action	\$98.20	Delasco.co m
MEDIUM TRAY IN ADDITION TO ABOVE (COST IS SUM OF BOTH)	\$1,439.75	

Scope & Instrument Cleaning Packages

The PEAC agreed upon the following standard sets of cleaning supplies needed for the typical scope and surgical instrument package:

Supplies typically used for Scope Cleaning and Disinfection

- 1 - liter of Cidex
- 1 - Gauze 4X 4 pad (10 Pack)
- 4 - pairs of Non Sterile Gloves
- 1 - Splash Shield
- 1 - Gown
- 2 oz – Isopropyl Alcohol 70%
- 1 – Cidex Solution Test Strips
- 1 - Electric Leakage Tester
- 1 – Endoscopic Bags (or wrapping material)
- 1 – Disposable Cleaning Brush

Supplies typically used for Surgical Instrument Package Cleaning

- 1 – Splash Shield
- 1 – Gown
- 1 – Disposable Brush
- 1 – 2 pairs of Non-Sterile Gloves
- 1 – Enzymetic Detergent
- 1 – Autoclave Bag with Indicator

AMA/Specialty Society RVS Update Committee
Recommendation

PEAC E/M Workgroup Report

Ronald Shellow, MD, (Chair)
Manuel Cerqueria, MD
Thomas Felger, MD
Scott Manaker, MD
Tye Ouzounian, MD
Julia M. Pillsbury, DO FAAP
Anthony Senagore, MD

The workgroup met to review a proposal from several specialty societies regarding the direct inputs for the remaining unrefined E/M codes. The American College of Physicians, American Academy of Family Physicians and the American Academy of Pediatrics developed recommendations for these remaining E/M codes. The recommendations were first revised internally within each specialty by consensus panels and then finalized by the PEAC members from these specialties.

The workgroup examined each code family separately. For many of the codes the clinical staff times presented were crosswalks to previously approved times for selected E/M codes. For each crosswalk, the workgroup discussed the similarities and differences in clinical staff time between the reference code and the codes under refinement. For the observation care codes the workgroup discussed in detail the appropriateness of cross walking the full 12 or 15 minutes currently assigned to 99238 and 99239. Although the observation care codes include admission and discharge on the same date the workgroup felt that the severity of these cases warrant using the full 12 and 15 minutes.

For many codes on the attached lists the workgroup agreed with the recommendation of zero clinical staff time such as for the inpatient consultation codes and in other instances only one or two phone calls was assigned due to limited clinical staff involvement.

The workgroup was comfortable with the recommended times for the subsequent nursing facility codes 99311, 99312, and 99313, providing that they are billed only once a month since the times assigned reflect the understanding that the clinical staff times reflect the clinical staff activities performed during the month.

The workgroup discussed the site of service attributed to the domiciliary, rest home and home visit codes. Currently CMS assigns a N/A status in the facility setting for these codes and the workgroup followed this convention, however, the workgroup would like to obtain a better understanding of how CMS assigns the site of service for these codes.

The preventative medicine codes generated a thorough discussion by the workgroup. The presenters explained that these services involve clinical staff work comparable to either level 4 or level 5 new and established patient codes. The workgroup questioned cross walking the inputs from these higher level E/M codes since some workgroup members felt that the clinical staff would not be spending that much time performing these activities. For the pediatric preventive care codes, the physician work increases with the patient's age, but the presenters stated that the clinical staff work remained constant at a high level due to the extensive interaction with the patient and the detailed histories. The presenters stated the clinical staff time for these codes far exceeds the physician time and although the physician work equated to lower level E/M codes, the clinical staff activities crosswalk to the higher level 4 E/M codes except for the 99387 and 99397, which are for patients 65 and older. For these two codes the time cross walked to level 5 visits. After the presenters described the clinical staff activities for the

Approved at the April 2003 RUC Meeting

pediatric preventive visits the workgroup was comfortable with the crosswalks. The clinical staff activities are described below:

Age appropriate social history

- Daycare, school, home
- Care givers eg. Single/dual parents, grandparents, etc.

Environmental History

- Tobacco risk/exposure
- Lead risk/exposure

Injury Risk Assessment History

- Car seat/booster seat/seat belts
- Fire/Home safety
- Sports

Infectious Disease Exposure/Risk

- TB, HIV, Hepatitis, other eg.:bioterrorism

Developmental History

- Language/ Social
- Fine motor and gross motor
- Cognitive: e.g.: school problems, ADD

Nutritional History/ nutritional counseling

Growth measurement including plotting on growth chart

Vision/Hearing Assessment by History—Formal testing where appropriate

Immunization History

Preventive Counseling

- Safety/development

The workgroup recommendations for these codes are attached.

CPT Codes Refined by the PEAC in March 2003

CPT Code Refinement *	Global Specialty(s) Involved	Descriptor	Extent of	
10180 010		Complex drainage, wound	Supplies & Equipment Only	AAOS
11772 090		Removal of pilonidal lesion		ACS
12020 010		Closure of split wound	Supplies & Equipment Only	AAOS
12021 010		Closure of split wound	Supplies & Equipment Only	AAOS
12036 010		Layer closure of wound(s)	Supplies & Equipment Only	AAOS
12037 010		Layer closure of wound(s)	Supplies & Equipment Only	AAOS
12045 010		Layer closure of wound(s)	Supplies & Equipment Only	AAOS
19020 090		Incision of breast lesion		ACS
19110 090		Nipple exploration		ACS
19112 090		Excise breast duct fistula		ACS
20000 010		Incision of abscess	Supplies & Equipment Only	AAOS
20005 010		Incision of deep abscess	Supplies & Equipment Only	AAOS
20100 010		Explore wound, neck	Facility Only	ASGS, ACS
20101 010		Explore wound, chest		ASGS, ACS
20102 010		Explore wound, abdomen		ASGS, ACS
20103 010		Explore wound, extremity	Supplies & Equipment Only	AAOS
20240 010		Bone biopsy, excisional	Supplies & Equipment Only	AAOS
20245 010		Bone biopsy, excisional	Supplies & Equipment Only	AAOS
20520 010		Removal of foreign body	Supplies & Equipment Only	AAOS
20525 010		Removal of foreign body	Supplies & Equipment Only	AAOS
20615 010		Treatment of bone cyst	Supplies & Equipment Only	AAOS
20650 010		Insert and remove bone pin	Supplies & Equipment Only	AAOS
20950 000		Fluid pressure, muscle	Supplies & Equipment Only	AAOS
20974 000		Electrical bone stimulation	Supplies & Equipment Only	AAOS
20975 000		Electrical bone stimulation	Supplies & Equipment Only	AAOS
21025 090		Excision of bone, lower jaw		AAOMS
21026 090		Excision of facial bone(s)		AAOMS, ASPS, AAOS
21029 090		Contour of face bone lesion		AAOMS, ASPS
21030 090		Removal of face bone lesion		AAOMS, ASPS
21031 090		Remove exostosis, mandible		AAOMS
21032 090		Remove exostosis, maxilla		AAOMS
21034 090		Removal of face bone lesion		AAO-HNS, AAOMS
21040 090		Removal of jaw bone lesion		AAOMS
21044 090		Removal of jaw bone lesion		AAOMS
21045 090		Extensive jaw surgery		AAOMS
21050 090		Removal of jaw joint		AAOMS
21060 090		Remove jaw joint cartilage		AAOMS
21070 090		Remove coronoid process		AAOMS
23030 010		Drain shoulder lesion		AAOS
23031 010		Drain shoulder bursa		AAOS
23065 010		Biopsy shoulder tissues		AAOS
23075 010		Removal of shoulder lesion		AAOS
23330 010		Remove shoulder foreign body		AAOS
23700 010		Fixation of shoulder		AAOS
23930 010		Drainage of arm lesion		AAOS
23931 010		Drainage of arm bursa		AAOS
24065 010		Biopsy arm/elbow soft tissue		AAOS
24200 010		Removal of arm foreign body		AAOS
24640 010		Treat elbow dislocation		AAOS
25065 010		Biopsy forearm soft tissues		AAOS
27040 010		Biopsy of soft tissues		AAOS
27086 010		Remove hip foreign body		AAOS

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 1 of 9

<i>CPT Code Refinement *</i>	<i>Global Specialty(s) Involved</i>	<i>Descriptor</i>	<i>Extent of</i>
27256 010		Treat hip dislocation	AAOS
27257 010		Treat hip dislocation	AAOS
27275 010		Manipulation of hip joint	AAOS
27323 010		Biopsy, thigh soft tissues	AAOS
27570 010		Fixation of knee joint	AAOS
27605 010		Incision of achilles tendon	AAOS
27606 010		Incision of achilles tendon	AAOS
27613 010		Biopsy lower leg soft tissue	AAOS
27860 010		Fixation of ankle joint	AAOS
28630 010		Treat toe dislocation	AAOS
28635 010		Treat toe dislocation	AAOS
28636 010		Treat toe dislocation	AAOS
28660 010		Treat toe dislocation	AAOS
28665 010		Treat toe dislocation	AAOS
31622 000		Dx bronchoscope/wash	ACCP
31623 000		Dx bronchoscope/brush	ACCP
31624 000		Dx bronchoscope/lavage	ACCP
31625 000		Bronchoscopy with biopsy	ACCP
31628 000		Bronchoscopy with biopsy	ACCP, ATS
31629 000		Bronchoscopy with biopsy	ACCP
31630 000		Bronchoscopy with repair	ACCP
31631 000		Bronchoscopy with dilation	ACCP
31635 000		Remove foreign body, airway	ACCP
31640 000		Bronchoscopy & remove lesion	ACCP
31641 000		Bronchoscopy, treat blockage	ACCP
31643 000		Diag bronchoscope/catheter	ACCP, ATS
31645 000		Bronchoscopy, clear airways	ACCP
31646 000		Bronchoscopy, reclear airway	ACCP
31656 000		Bronchoscopy, inj for xray	ACCP
31717 000		Bronchial brush biopsy	ACCP
36680 000		Insert needle, bone cavity	AAOS
40800 010		Drainage of mouth lesion	AAOMS
40801 010		Drainage of mouth lesion	AAOMS
40804 010		Removal, foreign body, mouth	AAOMS
40805 010		Removal, foreign body, mouth	AAOMS
40806 000		Incision of lip fold	AAOMS
40808 010		Biopsy of mouth lesion	AAOMS
40810 010		Excision of mouth lesion	AAOMS
40812 010		Excise/repair mouth lesion	AAOMS
40814 090		Excise/repair mouth lesion	AAOMS, ASPS
40816 090		Excision of mouth lesion	AAOMS, ASPS
40818 090		Excise oral mucosa for graft	AAOMS, ASPS
40819 090		Excise lip or cheek fold	AAOMS
40830 010		Repair mouth laceration	AAOMS
40831 010		Repair mouth laceration	AAOMS
41110 010		Excision of tongue lesion	AAOMS
41112 090		Excision of tongue lesion	AAOMS, ASPS
41113 090		Excision of tongue lesion	AAOMS, ASPS
41114 090		Excision of tongue lesion	AAOMS
43240 000		Esoph endoscope w/drain cyst	ASGE
43247 000		Operative upper GI endoscopy	ASGE
46040 090		Incision of rectal abscess	ACS, ASCoRS
46200 090		Removal of anal fissure	ACS, ASCoRS
46210 090		Removal of anal crypt	ACS, ASCoRS
46211 090		Removal of anal crypts	ACS, ASCoRS

* Where the extent of refinement is blank, all PE direct inputs were refined.

<i>CPT Code</i>	<i>Global Refinement *</i>	<i>Global Specialty(s) Involved</i>	<i>Descriptor</i>	<i>Extent of</i>
46221	010		Ligation of hemorrhoid(s)	ACS, ASCoRS
46250	090		Hemorrhoidectomy	ACS, ASCoRS
46255	090		Hemorrhoidectomy	ACS, ASCoRS
46270	090		Removal of anal fistula	ACS, ASCoRS
46275	090		Removal of anal fistula	ACS, ASCoRS
46285	090		Removal of anal fistula	ACS, ASCoRS
46934	090		Destruction of hemorrhoids	ACS, ASCoRS
46936	090		Destruction of hemorrhoids	ACS, ASCoRS
46938	090		Cryotherapy of rectal lesion	ACS, ASCoRS
46945	090		Ligation of hemorrhoids	ACS, ASCoRS
46946	090		Ligation of hemorrhoids	ACS, ASCoRS
50684	000		Injection for ureter x-ray	AUA
52214	000		Cystoscopy and treatment	Pre Service Clinical Labor Only AUA
52224	000		Cystoscopy and treatment	Pre Service Clinical Labor Only AUA
52234	000		Cystoscopy and treatment	Pre Service Clinical Labor Only AUA
52235	000		Cystoscopy and treatment	Pre Service Clinical Labor Only AUA
52240	000		Cystoscopy and treatment	Pre Service Clinical Labor Only AUA
56605	000		Biopsy of vulva/perineum	Pre Service Clinical Labor Only ACOG
56700	010		Partial removal of hymen	Pre Service Clinical Labor Only ACOG
56720	000		Incision of hymen	Pre Service Clinical Labor Only ACOG
56740	010		Remove vagina gland lesion	Pre Service Clinical Labor Only ACOG
57100	000		Biopsy of vagina	Pre Service Clinical Labor Only ACOG
57105	010		Biopsy of vagina	Pre Service Clinical Labor Only ACOG
57160	000		Insert pessary/other device	Pre Service Clinical Labor Only ACOG
57452	000		Examination of vagina	Pre Service Clinical Labor Only ACOG
57454	000		Vagina examination & biopsy	Pre Service Clinical Labor Only ACOG
57460	000		Cervix excision	Pre Service Clinical Labor Only ACOG
57500	000		Biopsy of cervix	Pre Service Clinical Labor Only ACOG, AAFP
58555	000		Hysteroscopy, dx, sep proc	Pre Service Clinical Labor Time Only ACOG
58558	000		Hysteroscopy, biopsy	Pre Service Clinical Labor Time Only ACOG
58559	000		Hysteroscopy, lysis	Pre Service Clinical Labor Time Only ACOG
58560	000		Hysteroscopy, resect septum	Pre Service Clinical Labor Time Only ACOG
58561	000		Hysteroscopy, remove myoma	Pre Service Clinical Labor Time Only ACOG
58563	000		Hysteroscopy, ablation	Pre Service Clinical Labor Time Only ACOG
58800	090		Drainage of ovarian cyst(s)	Pre Service Clinical Labor Time Only ACOG
59140	090		Treat ectopic pregnancy	Pre Service Clinical Labor Time Only ACOG
59820	090		Care of miscarriage	Pre Service Clinical Labor Time Only ACOG
59821	090		Treatment of miscarriage	Pre Service Clinical Labor Time Only ACOG
62270	000		Spinal fluid tap, diagnostic	AAPM&R, NASS
62272	000		Drain cerebro spinal fluid	AAPM&R, NASS
62273	000		Treat epidural spine lesion	AAPM&R, NASS
62280	010		Treat spinal cord lesion	AAPM&R, NASS, ASA
62281	010		Treat spinal cord lesion	AAPM&R, NASS, ASA
62282	010		Treat spinal canal lesion	AAPM&R, NASS, ASA
62284	000		Injection for myelogram	AAPM&R, NASS
62290	000		Inject for spine disk x-ray	AAPM&R, NASS
62291	000		Inject for spine disk x-ray	AAPM&R, NASS
62310	000		Inject spine c/t	AAPM&R, NASS, ASA
62311	000		Inject spine l/s (cd)	AAPM&R, NASS, ASA
62318	000		Inject spine w/cath, c/t	AAPM&R, NASS, ASA
62319	000		Inject spine w/cath l/s (cd)	AAPM&R, NASS, ASA
62367	XXX		Analyze spine infusion pump	In office only ASA
62368	XXX		Analyze spine infusion pump	In office only ASA
64400	000		Injection for nerve block	AAPM&R, NASS, ASA
64402	000		Injection for nerve block	AAPM&R, NASS, ASA

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 3 of 9

<i>CPT Code</i>	<i>Global</i>	<i>Descriptor</i>	<i>Extent of</i>
<i>Refinement *</i>	<i>Specialty(s) Involved</i>		
64405	000	Injection for nerve block	AAPM&R, NASS, ASA
64408	000	Injection for nerve block	AAPM&R, NASS, ASA
64410	000	Injection for nerve block	AAPM&R, NASS, ASA
64412	000	Injection for nerve block	AAPM&R, NASS, ASA
64413	000	Injection for nerve block	AAPM&R, NASS, ASA
64415	000	Injection for nerve block	AAPM&R, NASS, ASA
64417	000	Injection for nerve block	AAPM&R, NASS, ASA
64418	000	Injection for nerve block	AAPM&R, NASS, ASA
64420	000	Injection for nerve block	AAPM&R, NASS, ASA
64421	000	Injection for nerve block	AAPM&R, NASS, ASA
64425	000	Injection for nerve block	AAPM&R, NASS, ASA
64430	000	Injection for nerve block	AAPM&R, NASS, ASA
64435	000	Injection for nerve block	AAPM&R, NASS, ASA
64445	000	Injection for nerve block	AAPM&R, NASS, ASA
64450	000	Injection for nerve block	AAPM&R, NASS, ASA
64470	000	Inj paravertebral c/t	AAPM&R, NASS, ASA
64475	000	Inj paravertebral l/s	AAPM&R, NASS, ASA
64479	000	Inj foramen epidural c/t	AAPM&R, NASS, ASA
64483	000	Inj foramen epidural l/s	AAPM&R, NASS, ASA
64505	000	Injection for nerve block	AAPM&R, NASS, ASA
64508	000	Injection for nerve block	AAPM&R, NASS, ASA
64510	000	Injection for nerve block	AAPM&R, NASS, ASA
64520	000	Injection for nerve block	AAPM&R, NASS, ASA
64530	000	Injection for nerve block	AAPM&R, NASS, ASA
64600	010	Injection treatment of nerve	AAPM&R, NASS, ASA
64605	010	Injection treatment of nerve	AAPM&R, NASS, ASA
64610	010	Injection treatment of nerve	AAPM&R, NASS, ASA
64612	010	Destroy nerve, face muscle	AAPM&R, NASS
64613	010	Destroy nerve, spine muscle	AAPM&R, NASS
64614	010	Destroy nerve, extrem musc	AAPM&R, NASS, ASA
64620	010	Injection treatment of nerve	AAPM&R, NASS, ASA
64622	010	Destr paravertebrl nerve l/s	AAPM&R, NASS, ASA
64626	010	Destr paravertebrl nerve c/t	AAPM&R, NASS, ASA
64630	010	Injection treatment of nerve	AAPM&R, NASS, ASA
64640	010	Injection treatment of nerve	AAPM&R, NASS, ASA
64680	010	Injection treatment of nerve	AAPM&R, NASS, ASA
65125	090	Revise ocular implant	AAO
65205	000	Remove foreign body from eye	AAO, AOA
65210	000	Remove foreign body from eye	AAO, AOA
65220	000	Remove foreign body from eye	AAO
65222	000	Remove foreign body from eye	AAO, AOA
65270	010	Repair of eye wound	AAO
65272	090	Repair of eye wound	AAO, AOA
65273	090	Repair of eye wound	AAO
65275	090	Repair of eye wound	AAO, AOA
65280	090	Repair of eye wound	AAO
65285	090	Repair of eye wound	AAO
65286	090	Repair of eye wound	AAO
65290	090	Repair of eye socket wound	AAO
65400	090	Removal of eye lesion	AAO
65410	000	Biopsy of cornea	AAO
65420	090	Removal of eye lesion	AAO
65426	090	Removal of eye lesion	AAO
65430	000	Corneal smear	AAO
65435	000	Curette/treat cornea	AAO

* Where the extent of refinement is blank, all PE direct inputs were refined.

<i>CPT Code</i>	<i>Global Refinement *</i>	<i>Global Specialty(s) Involved</i>	<i>Descriptor</i>	<i>Extent of</i>
65436	090		Curette/treat cornea	AAO, AOA
65450	090		Treatment of corneal lesion	AAO
65600	090		Revision of cornea	AAO, AOA
65771	XXX		Radial keratotomy	AAO
65772	090		Correction of astigmatism	AAO
65800	000		Drainage of eye	AAO
65805	000		Drainage of eye	AAO
65810	090		Drainage of eye	AAO
65815	090		Drainage of eye	AAO
65855	010		Laser surgery of eye	AAO
65860	090		Incise inner eye adhesions	AAO
66130	090		Remove eye lesion	AAO
66250	090		Follow-up surgery of eye	AAO
66625	090		Removal of iris	AAO
66630	090		Removal of iris	AAO
66635	090		Removal of iris	AAO
67025	090		Replace eye fluid	AAO
67027	090		Implant eye drug system	AAO
67028	000		Injection eye drug	AAO
67031	090		Laser surgery, eye strands	AAO
67101	090		Repair detached retina	AAO
67105	090		Repair detached retina	AAO
67107	090		Repair detached retina	AAO
67108	090		Repair detached retina	AAO
67110	090		Repair detached retina	AAO
67112	090		Rerepair detached retina	AAO
67115	090		Release encircling material	AAO
67120	090		Remove eye implant material	AAO
67121	090		Remove eye implant material	AAO
67141	090		Treatment of retina	AAO
67145	090		Treatment of retina	AAO
67500	000		Inject/treat eye socket	AAO
67505	000		Inject/treat eye socket	AAO
67515	000		Inject/treat eye socket	AAO
67800	010		Remove eyelid lesion	AAO
67801	010		Remove eyelid lesions	AAO
67805	010		Remove eyelid lesions	AAO
67808	090		Remove eyelid lesion(s)	AAO
67820	000		Revise eyelashes	AAO
67825	010		Revise eyelashes	AAO
67875	000		Closure of eyelid by suture	AAO
67880	090		Revision of eyelid	AAO
67882	090		Revision of eyelid	AAO
67900	090		Repair brow defect	AAO, ASPS
67901	090		Repair eyelid defect	AAO
67902	090		Repair eyelid defect	AAO
67903	090		Repair eyelid defect	AAO, ASPS
67904	090		Repair eyelid defect	AAO, ASPS
67906	090		Repair eyelid defect	AAO, ASPS
67908	090		Repair eyelid defect	AAO, ASPS
67909	090		Revise eyelid defect	AAO, ASPS
67911	090		Revise eyelid defect	AAO
67914	090		Repair eyelid defect	AAO, ASPS
67915	090		Repair eyelid defect	AAO, ASPS
67916	090		Repair eyelid defect	AAO, ASPS

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 5 of 9

<i>CPT Code</i>	<i>Global</i>	<i>Descriptor</i>	<i>Extent of</i>
<i>Refinement *</i>	<i>Specialty(s) Involved</i>		
67917	090	Repair eyelid defect	AAO, ASPS
67921	090	Repair eyelid defect	AAO, ASPS
67922	090	Repair eyelid defect	AAO, ASPS
67923	090	Repair eyelid defect	AAO, ASPS
67924	090	Repair eyelid defect	AAO, ASPS
67930	010	Repair eyelid wound	AAO
67935	090	Repair eyelid wound	AAO, ASPS
67938	010	Remove eyelid foreign body	AAO
67950	090	Revision of eyelid	AAO, ASPS
67961	090	Revision of eyelid	AAO
67966	090	Revision of eyelid	AAO, ASPS
67971	090	Reconstruction of eyelid	AAO
67973	090	Reconstruction of eyelid	AAO
67974	090	Reconstruction of eyelid	AAO
67975	090	Reconstruction of eyelid	AAO
68020	010	Incise/drain eyelid lining	AAO
68040	000	Treatment of eyelid lesions	AAO
68100	000	Biopsy of eyelid lining	AAO
68110	010	Remove eyelid lining lesion	AAO
68115	010	Remove eyelid lining lesion	AAO
68130	090	Remove eyelid lining lesion	AAO
68135	010	Remove eyelid lining lesion	AAO
68200	000	Treat eyelid by injection	AAO
68320	090	Revise/graft eyelid lining	AAO, ASPS
68325	090	Revise/graft eyelid lining	AAO
68326	090	Revise/graft eyelid lining	AAO
68328	090	Revise/graft eyelid lining	AAO
68330	090	Revise eyelid lining	AAO, ASPS
68335	090	Revise/graft eyelid lining	AAO
68340	090	Separate eyelid adhesions	AAO, ASPS
68360	090	Revise eyelid lining	AAO, ASPS
68362	090	Revise eyelid lining	AAO
68440	010	Incise tear duct opening	AAO
68700	090	Repair tear ducts	AAO
68705	010	Revise tear duct opening	AAO
68760	010	Close tear duct opening	AAO
68761	010	Close tear duct opening	AAO
68770	090	Close tear system fistula	AAO, ASPS
68801	010	Dilate tear duct opening	AAO
68810	010	Probe nasolacrimal duct	AAO
68811	010	Probe nasolacrimal duct	AAO
68815	010	Probe nasolacrimal duct	AAO
68840	010	Explore/irrigate tear ducts	AAO
68850	000	Injection for tear sac x-ray	AAO
88348	XXX	Electron microscopy	CAP
88349	XXX	Scanning electron microscopy	CAP
90865	XXX	Narcosynthesis	Am Psych Assn
90870	000	Electroconvulsive therapy	Am Psych Assn
90875	XXX	Psychophysiological therapy	Am Psych Assn
90876	XXX	Psychophysiological therapy	Am Psych Assn
90885	XXX	Psy evaluation of records	Am Psych Assn
91000	000	Esophageal intubation	AGA
91010	000	Esophagus motility study	AGA
91011	000	Esophagus motility study	AGA
91012	000	Esophagus motility study	AGA

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 6 of 9

CPT Code	Global	Descriptor	Extent of
Refinement *	Specialty(s) Involved		
91020	000	Gastric motility	AGA
91030	000	Acid perfusion of esophagus	AGA
91032	000	Esophagus, acid reflux test	AGA
91033	000	Prolonged acid reflux test	AGA
91052	000	Gastric analysis test	AGA
91055	000	Gastric intubation for smear	AGA
91060	000	Gastric saline load test	AGA
91065	000	Breath hydrogen test	AGA
91100	000	Pass intestine bleeding tube	AGA
91105	000	Gastric intubation treatment	AGA
92950	000	Heart/lung resuscitation cpr	ACCP
93721	XXX	Plethysmography tracing	ACCP
94450	XXX	Hypoxia response curve	ACCP, ATS
94770	XXX	Exhaled carbon dioxide test	ACCP, ATS
95180	000	Rapid desensitization	JCAAI
95965	XXX	Meg, spontaneous	ACNS, AAN
95966	XXX	Meg, evoked, single	ACNS, AAN
95967	ZZZ	Meg, evoked, each addl	ACNS, ANN
99217	XXX	Observation care discharge	ACP, AAFP, AAP
99218	XXX	Observation care	ACP, AAFP, AAP
99219	XXX	Observation care	ACP, AAFP, AAP
99220	XXX	Observation care	ACP, AAFP, AAP
99221	XXX	Initial hospital care	ACP, AAFP, AAP
99222	XXX	Initial hospital care	ACP, AAFP, AAP
99223	XXX	Initial hospital care	ACP, AAFP, AAP
99231	XXX	Subsequent hospital care	ACP, AAFP, AAP
99232	XXX	Subsequent hospital care	ACP, AAFP, AAP
99233	XXX	Subsequent hospital care	ACP, AAFP, AAP
99234	XXX	Observ/hosp same date	ACP, AAFP, AAP
99235	XXX	Observ/hosp same date	ACP, AAFP, AAP
99236	XXX	Observ/hosp same date	ACP, AAFP, AAP
99241	XXX	Office consultation	ACP, AAFP, AAP
99242	XXX	Office consultation	ACP, AAFP, AAP
99243	XXX	Office consultation	ACP, AAFP, AAP
99244	XXX	Office consultation	ACP, AAFP, AAP
99245	XXX	Office consultation	ACP, AAFP, AAP
99251	XXX	Initial inpatient consult	ACP, AAFP, AAP
99252	XXX	Initial inpatient consult	ACP, AAFP, AAP
99253	XXX	Initial inpatient consult	ACP, AAFP, AAP
99254	XXX	Initial inpatient consult	ACP, AAFP, AAP
99255	XXX	Initial inpatient consult	ACP, AAFP, AAP
99261	XXX	Follow-up inpatient consult	ACP, AAFP, AAP
99262	XXX	Follow-up inpatient consult	ACP, AAFP, AAP
99263	XXX	Follow-up inpatient consult	ACP, AAFP, AAP
99271	XXX	Confirmatory consultation	ACP, AAFP, AAP
99272	XXX	Confirmatory consultation	ACP, AAFP, AAP
99273	XXX	Confirmatory consultation	ACP, AAFP, AAP
99274	XXX	Confirmatory consultation	ACP, AAFP, AAP
99275	XXX	Confirmatory consultation	ACP, AAFP, AAP
99281	XXX	Emergency dept visit	ACP, AAFP, AAP
99282	XXX	Emergency dept visit	ACP, AAFP, AAP
99283	XXX	Emergency dept visit	ACP, AAFP, AAP
99284	XXX	Emergency dept visit	ACP, AAFP, AAP
99285	XXX	Emergency dept visit	ACP, AAFP, AAP
99288	XXX	Direct advanced life support	ACP, AAFP, AAP

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 7 of 9

CPT Code Refinement *	Global Specialty(s) Involved	Descriptor	Extent of
99289	XXX	Pt transport, 30-74 min	ACP, AAFP, AAP
99290	ZZZ	Pt transport, addl 30 min	ACP, AAFP, AAP
99291	XXX	Critical care, first hour	ACP, AAFP, AAP
99292	ZZZ	Critical care, addl 30 min	ACP, AAFP, AAP
99293			ACP, AAFP, AAP
99294			ACP, AAFP, AAP
99295	XXX	Neonatal critical care	ACP, AAFP, AAP
99296	XXX	Neonatal critical care	ACP, AAFP, AAP
99298	XXX	Neonatal critical care	ACP, AAFP, AAP
99299			ACP, AAFP, AAP
99301	XXX	Nursing facility care	ACP, AAFP, AAP
99302	XXX	Nursing facility care	ACP, AAFP, AAP
99303	XXX	Nursing facility care	ACP, AAFP, AAP
99311	XXX	Nursing fac care, subseq	ACP, AAFP, AAP
99312	XXX	Nursing fac care, subseq	ACP, AAFP, AAP
99313	XXX	Nursing fac care, subseq	ACP, AAFP, AAP
99315	XXX	Nursing fac discharge day	ACP, AAFP, AAP
99316	XXX	Nursing fac discharge day	ACP, AAFP, AAP
99321	XXX	Rest home visit, new patient	ACP, AAFP, AAP
99322	XXX	Rest home visit, new patient	ACP, AAFP, AAP
99323	XXX	Rest home visit, new patient	ACP, AAFP, AAP
99331	XXX	Rest home visit, est pat	ACP, AAFP, AAP
99332	XXX	Rest home visit, est pat	ACP, AAFP, AAP
99333	XXX	Rest home visit, est pat	ACP, AAFP, AAP
99341	XXX	Home visit, new patient	ACP, AAFP, AAP
99342	XXX	Home visit, new patient	ACP, AAFP, AAP
99343	XXX	Home visit, new patient	ACP, AAFP, AAP
99344	XXX	Home visit, new patient	ACP, AAFP, AAP
99345	XXX	Home visit, new patient	ACP, AAFP, AAP
99347	XXX	Home visit, est patient	ACP, AAFP, AAP
99348	XXX	Home visit, est patient	ACP, AAFP, AAP
99349	XXX	Home visit, est patient	ACP, AAFP, AAP
99350	XXX	Home visit, est patient	ACP, AAFP, AAP
99354	ZZZ	Prolonged service, office	ACP, AAFP, AAP
99355	ZZZ	Prolonged service, office	ACP, AAFP, AAP
99356	ZZZ	Prolonged service, inpatient	ACP, AAFP, AAP
99357	ZZZ	Prolonged service, inpatient	ACP, AAFP, AAP
99358	ZZZ	Prolonged serv, w/o contact	ACP, AAFP, AAP
99359	ZZZ	Prolonged serv, w/o contact	ACP, AAFP, AAP
99360	XXX	Physician standby services	ACP, AAFP, AAP
99361	XXX	Physician/team conference	ACP, AAFP, AAP
99362	XXX	Physician/team conference	ACP, AAFP, AAP
99371	XXX	Physician phone consultation	ACP, AAFP, AAP
99372	XXX	Physician phone consultation	ACP, AAFP, AAP
99373	XXX	Physician phone consultation	ACP, AAFP, AAP
99374	XXX	Home health care supervision	ACP, AAFP, AAP
99375			ACP, AAFP, AAP
99377	XXX	Hospice care supervision	ACP, AAFP, AAP
99378			ACP, AAFP, AAP
99379	XXX	Nursing fac care supervision	ACP, AAFP, AAP
99380	XXX	Nursing fac care supervision	ACP, AAFP, AAP
99381	XXX	Prev visit, new, infant	ACP, AAFP, AAP
99382	XXX	Prev visit, new, age 1-4	ACP, AAFP, AAP
99383	XXX	Prev visit, new, age 5-11	ACP, AAFP, AAP
99384	XXX	Prev visit, new, age 12-17	ACP, AAFP, AAP

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 8 of 9

CPT Code Refinement *	Global Specialty(s) Involved	Descriptor	Extent of
99385	XXX	Prev visit, new, age 18-39	ACP, AAFP, AAP
99386	XXX	Prev visit, new, age 40-64	ACP, AAFP, AAP
99387	XXX	Prev visit, new, 65 & over	ACP, AAFP, AAP
99391	XXX	Prev visit, est, infant	ACP, AAFP, AAP
99392	XXX	Prev visit, est, age 1-4	ACP, AAFP, AAP
99393	XXX	Prev visit, est, age 5-11	ACP, AAFP, AAP
99394	XXX	Prev visit, est, age 12-17	ACP, AAFP, AAP
99395	XXX	Prev visit, est, age 18-39	ACP, AAFP, AAP
99396	XXX	Prev visit, est, age 40-64	ACP, AAFP, AAP
99397	XXX	Prev visit, est, 65 & over	ACP, AAFP, AAP
99401	XXX	Preventive counseling, indiv	ACP, AAFP, AAP
99402	XXX	Preventive counseling, indiv	ACP, AAFP, AAP
99403	XXX	Preventive counseling, indiv	ACP, AAFP, AAP
99404	XXX	Preventive counseling, indiv	ACP, AAFP, AAP
99411	XXX	Preventive counseling, group	ACP, AAFP, AAP
99412	XXX	Preventive counseling, group	ACP, AAFP, AAP
99420	XXX	Health risk assessment test	ACP, AAFP, AAP
99431	XXX	Initial care, normal newborn	ACP, AAFP, AAP
99432	XXX	Newborn care, not in hosp	ACP, AAFP, AAP
99433	XXX	Normal newborn care/hospital	ACP, AAFP, AAP
99435	XXX	Newborn discharge day hosp	ACP, AAFP, AAP
99436	XXX	Attendance, birth	ACP, AAFP, AAP
99440	XXX	Newborn resuscitation	ACP, AAFP, AAP
99450	XXX	Life/disability evaluation	ACP, AAFP, AAP
99455	XXX	Disability examination	ACP, AAFP, AAP
99456	XXX	Disability examination	ACP, AAFP, AAP

* Where the extent of refinement is blank, all PE direct inputs were refined.

Page 9 of 9

Approved at the April 2003 RUC Meeting

**RUC HCPAC Review Board Report
Hotel Intercontinental
Chicago, Illinois
April 24, 2003**

On April 24, 2003, the RUC HCPAC Board met to receive an update on the relative value recommendations for the CNS Assessments/Tests, to assess the recommendations for Rehabilitation Assessment and Integration Services codes and to elect a new HCPAC Co-Chair and Alternate Co-Chair. The following HCPAC Review Board members participated in the discussion:

Richard Whitten, MD, Chair
Don E. Williamson, OD, Co-Chair
Jonathon Cooperman, MS, PT, JD
Robert Fifer, PhD
Mary Foto, OT
James Georgoulakis, PhD
Tony Hamm, DC

Emily H. Hill, PA-C
David Keepnews, PhD, JD, RN, FAAN
Marc Lenet, DPM
Bernard Pfeifer, MD
Karen Smith, MS, RD, FADA
Nelda Spryres, LCSW
Arthur Traugott, MD

I. Call to Order

Dr. Williamson called the meeting to order at 7:05 a.m.

II. Introduction

Dr. Williamson introduced new RUC HCPAC Review Board members:

- Jonathon Cooperman, MS, PT, JD, American Physical Therapy Association
- Tony Hamm, DC, American Chiropractic Association

III. Update on the Relative Value Recommendations for the CNS Assessments/Tests (96100, 96105, 96115, and 96117)

Dr. Georgoulakis gave a brief history of the CNS Assessments/Tests codes and updated the HCPAC Review Board on the progress of formulating relative value recommendations. He stated that because of the challenges that arose using the RUC approved modified survey instrument for the data presented at the January RUC 2003 meeting that the APA has decided to use the standard RUC survey instrument in this current evaluative process. APA will present the new recommendations for these codes at the September 2003 HCPAC meeting.

IV. Relative Value Recommendation for CPT 2004 Rehabilitation Assessment and Integration Services (97537 and 977XX)

Ms. Foto presented the relative value recommendations for the Rehabilitation Assessment and Integration Services. These codes were created to describe the specific skills and knowledge required to successfully assess and manage people with severe disabilities, i.e. a C3 or C4 patient. She began by stating that the changes in the CPT descriptor for code 97537 were editorial in nature and do not affect the work RVU. In the extensive discussion of the relative value recommendation for 977XX, it was determined that this code is more intense and takes more time to complete than the reference service, 97535. Therefore, the HCPAC approved the society recommended 0.62 work RVU recommendation. Additionally, supplies and equipment for all of the codes were assessed, modified and approved by the HCPAC.

V. Election of HCPAC Co-Chair and Alternate Co-Chair

Mary Foto, OT and Nelda Spyles, LCSW were elected RUC HCPAC Co-Chair and Alternate Co-Chair, respectively. Their terms begin with the September 2003 RUC HCPAC Review Board Meeting.

VI. Other Issues

Dr. Whitten announced that this meeting is Dr. Williamson's last meeting as the RUC HCPAC Co-Chair. He thanked Dr. Williamson on behalf of the committee for his four years of service and leadership.

IV. Adjournment

Dr. Williamson adjourned the meeting at 8:55 a.m.

**Zero Physician Work Pool Workgroup
April 24, 2003**

The following workgroup members participated in the meeting: Melvin Britton, MD (Chair), Bibb Allen, MD, James Blankenship, MD, MD, Robert Fifer, PhD, Susan Strate, MD, J. Baldwin Smith, MD, Richard Tuck, MD, Robert Zwolak, MD.

The workgroup heard a presentation from Marc Hartstein, CMS who described the practice expense methodology and provided a detailed explanation of the methodology using an actual code and associated data to determine the code's PERVU. The data used to calculate the global period PERVU under the standard methodology was shown in a side by side comparison to the TC component PERVU, which was calculated using the zero work pool methodology. Both the similarities and differences between the two methodologies were highlighted and Mr. Hartstein showed how the SMS and CPEP derived cost pools are used to allocate costs.

During the presentation, the workgroup focused on the differences between the SMS estimated costs and the CPEP estimated costs. A scaling factor is used to reconcile the differences between the two cost pools. In the example presented, the SMS equipment costs were only 9% of the CPEP calculated equipment costs. The conclusions that can be derived from these data are that either the SMS survey respondents underestimated costs, or the CPEP data may be overestimated. Another possibility is that the physicians surveyed for the SMS did not have substantial medical equipment in their offices since they primarily practice in the hospital. While a goal is to have the SMS cost pools be somewhat similar to the size of the CPEP data pools, it was Mr. Hartstein's opinion that any shortcomings may be due to the data and not the overall methodology.

Doctor Allen observed that the SMS data has significant effect on the cost allocation model and for radiology, the SMS survey may not have been adequately stratified to collect cost data from radiologists in different practice settings. For example, only about 10% of radiologists own their own equipment and additional survey data may be needed to obtain accurate cost data for this subset of radiologists. Currently, most radiologists practice primarily in hospitals and have low equipment costs. Additional survey data is needed to determine the equipment costs for those physicians that do perform radiology procedures in their office or in a free standing imaging facility. A typical scenario is one in which a physician performs procedures in a diagnostic center and the center submits global bills under the physician's provider number. Although all of these charges are listed as provided by the physician, the site of service is the diagnostic center, whose costs are not currently reflected in the SMS data. Most likely, the practice expenses reflected in the SMS survey data would not include the equipment and technical clinical staff expenses of a diagnostic center or another setting where the physician owns the equipment. To better understand the costs involved in providing these equipment intensive services, Radiology is in the process of collecting additional survey data to obtain better stratified data.

Doctor Zwolak stated that the data presented to the workgroup demonstrated that there has been an underestimation of some costs for codes included in the zero work pool. One possibility to help overcome some of the zero work pool deficiencies would be to survey

those that provide TC only services separately from those that provide the professional component. Additionally, whenever the new data is analyzed it should be compared to actual procedure cost data that show the costs for certain procedures. This would ensure that a reality check on the PE methodology.

The workgroup agreed that the two major determinants of the PE RVUs are the SMS derived PE/hour data and the CPEP data used to allocate costs. For the codes in the zero physician work pool, a number of specialties are working with CMS to collect additional stratified PE data. Additionally, all of the codes in the zero physician work pool are being refined by the PEAC. Therefore, the two main sources of data are currently in refinement. In light of this, the workgroup did not make a specific recommendation for the RUC at this time, preferring to wait until these additional data sets are available.

**AMA/Specialty Society RVS Update Committee
Conscious Sedation Workgroup
Thursday, April 24, 2003**

Doctors William Gee (Chairman), Norm Cohen, John Derr, Lee Eisenberg, Lanny Garvar, Steven Krug, Charles Mick, Alan Plummer, Zachary Rattner, MD Maurits Wiersema, and David Keepnews, PhD, JD, RN. met on Thursday, April 24 to finalize the list of CPT codes that inherently include conscious sedation and develop a recommendation to the CPT Editorial Panel.

Prior to the initiation of the agenda for this meeting, a workgroup member expressed concern that the progression of this conscious sedation project may impede the ability of some physicians to continue to receive payment from private payors for the conscious sedation codes when reported with a service on the list. It was noted that the practice expense inputs required to provide conscious sedation have been explicitly included in these codes and that separate reporting of conscious sedation would not be appropriate, either to Medicare or private payors. The workgroup member made a motion to disband the workgroup prior to initiating a final report. This motion was not seconded by any other workgroup member.

Finalization of the List of Codes Submitted by Specialty Societies – Conscious Sedation Inherent in Providing the Service

The workgroup reviewed a list of 229 codes proposed by specialty societies to inherently include conscious sedation. This list includes several codes recently added by the Society for Interventional Radiology. The workgroup noted that the new CPT codes discussed at this meeting (eg, central venous access) would also be added to this list.

One question was raised regarding the bronchoscopy services included on the list. The codes include either the use of rigid or flexible scope. If a rigid scope is utilized, the service is typically performed under general anesthesia. The specialty indicated that currently the vast majority of these services are performed using a flexible scope and that if rigid were to become more prevalent, they may seek CPT coding changes.

A workgroup member expressed concern that there may be CPT codes that were not appropriately identified by specialties during this project that do indeed inherently include conscious sedation. It was noted that while there is an incentive to include the code on the list if it is provided in an office setting to capture the practice expense inputs, those services only performed in the facility may not have been identified. The workgroup discussed an annual review to allow for analysis of Medicare data to determine if certain procedure codes are routinely accompanied by a conscious sedation code.

The workgroup recommends the adoption of the attached list of 229 CPT codes (plus new codes from this RUC meeting) as representing those services that inherently include conscious sedation.

Recommendation to the CPT Editorial Panel

The workgroup then reviewed and made various revisions to the attached document *Recommendation to the CPT Editorial Panel*. This document will be considered by CPT in the *CPT 2005* coding cycle and a representative from the RUC will attend the meeting to explain the issue to the Panel.

In regards to the first recommendation, the workgroup wished to clarify that additions or deletions of codes from the conscious sedation list must be approved by the RUC and submitted to the CPT Editorial Panel. This is important as the RUC should ensure that only codes currently on the list retain direct practice expense inputs related to conscious sedation. The workgroup understands that CPT is most likely to use language such as “Do not report 99141 – 99142 in addition to these services.” Recommendation one should now read as follows:

- 1. The CPT Editorial Panel should consider the addition of an Appendix in CPT to specifically identify the 229(+) CPT codes which inherently include conscious sedation, provided by the operating physician. This list may be updated annually as new CPT codes are added or to address codes where changes in practice lead to changes as to whether conscious sedation is inherently included. Addition or deletion of codes from the list must be approved by the RUC and submitted to the CPT Editorial Panel.**

Several workgroup members expressed concern that payors do not interpret this appendix in CPT to imply that anesthesiologists, or other qualified providers, would not be able to report anesthesia codes if their services were utilized in conjunction with a procedure code included on this list. The workgroup extensively discussed the appropriate language to convey that this type of payment policy should not arise from this appendix and recommends the following:

- 2. The Appendix should include an explanatory note that “the inclusion of a procedure on this list does not prevent separate reporting of an associated anesthesia procedure/service (CPT codes 00100-01999) when performed by a provider (such as an anesthesiologist or CRNA) other than the operating physician.”**

Finally, the workgroup recommends that the current conscious sedation codes be revised to allow for the reporting of conscious sedation by increments of time. The workgroup offers the following language to serve as a framework for the Panel to consider:

- 3. Revision to the CPT codes for conscious sedation (99141 and 99142) and addition of new add-on codes to allow the reporting of conscious sedation on an increment of conscious sedation time during the procedure. A cross-reference directing the user to the new Appendix should also be added to these codes.**

99141 Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation; initial 15 minutes

99!X! each additional 15 minutes

99142 Sedation with or without analgesia (conscious sedation); oral, rectal, and/or intranasal; initial 15 minutes

991X2 each additional 15 minutes

After the CPT Editorial Panel acts on this recommendation, these codes will flow through the RUC process for evaluation.

- 4. Revision to the Anesthesia section notes in CPT to clarify that the reference to the conscious sedation codes only applies to physicians who are performing the procedure. A clarification should be made that when any physician, other than the physician performing the procedure, provides anesthesia services (conscious sedation or otherwise), the Anesthesia codes should be reported.**

Other Issues

The RUC included an update on this project to CMS in the comment letter on the *Final Rule* for the 2003 Medicare Payment Schedule. The RUC will share the latest update with CMS in its provision of recommendations in May 2003. CMS staff at the meeting indicated that they will review this issue as it develops through CPT and the conscious sedation codes are then evaluation by the RUC in the *CPT 2005* cycle.

With the finalization of this list of codes and the development of the recommendation to CPT, the Conscious Sedation Workgroup offers that its work has been completed and suggests to the RUC that it be disbanded.

**AMA/Specialty Society RVS Update Committee
Recommendation to the CPT Editorial Panel
Conscious Sedation**

Background

In 2000, the gastroenterology community commented in the Five-Year Review of the Resource-Based Relative Value Scale (RBRVS) that the physician work involved in the provision of conscious sedation had changed over the past five-years. Gastroenterology specifically argued that the work of conscious sedation had been included in the work relative values for many of their procedural codes, since the inception of the RBRVS. However, gastroenterology asserted that JCAHO and specialty guidelines had increased the amount of documentation and other procedures related to this service since the Harvard studies.

The RUC exhaustively reviewed these arguments, including documents dating back to the time of the Harvard RBRVS project. The RUC determined that the issues related to conscious sedation do not merely apply to gastroenterology, but to many specialties. The RUC formed a Conscious Sedation Workgroup, chaired by Doctor William F. Gee, which has met consistently over the past two years to develop recommendations and solutions for this issue.

The RUC is submitting this proposal to the CPT Editorial Panel to specifically identify which procedural codes inherently include conscious sedation, provided by the operating physician, or under the direction of the operating physician. Physician work and direct practice expense related to conscious sedation are, or will be, allocated to these services.

RUC Actions/Decisions

The RUC has compiled a list of 229 (+) codes that, in today's practice, inherently include conscious sedation provided by the physician performing the procedure. Specialties were asked to consider all types of sedation, including intravenous, intramuscular, inhalation, oral, rectal, and intranasal. It is not necessary to specify which type of sedation is typical. These codes represent services where the sedation is administered by or under the supervision of the operator (physician performing the procedure).

If conscious sedation is performed in conjunction with a procedure where it is not inherent (not included on this list and hence where the resources have not been captured in that service), then the physician will be instructed to report the appropriate stand-alone conscious sedation code(s). An outcome that is desired is that through these efforts, the RUC and the AMA can more effectively lobby for separate payment for conscious sedation, where appropriate.

If conscious sedation is an inherent part of the procedure, but is most typically provided by an anesthesiologist or CRNA, the code was not included on this conscious sedation list. In addition, the RUC recommends that CPT include language that clarifies that the inclusion of a procedure on this list does not prevent separate reporting of an associated anesthesia service/code when performed by an anesthesiologist or CRNA.

The following 54 specialty societies responded to multiple inquiries during the development of the list:

American Academy of Allergy and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology-Head and Neck Surgery, Inc.
American Academy of Pain Medicine
American Academy of Pediatrics
American Academy of Pharmaceutical Physicians
American Academy of Physicians Assistants
American Association of Oral and Maxillofacial Surgeons
American Association of Plastic Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Surgeons
American Dental Association
American Gastroenterological Association
American Geriatrics Society
American Institute of Ultrasound in Medicine
American Optometric Association
American Orthopaedic Foot and Ankle Society
American Pediatric Surgery Association
American Physical Therapy Association
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Society of Aesthetic Plastic Surgery

American Society of Anesthesiologists
American Society of Colon and Rectal Surgeons
American Society of Cytopathology
American Society of Gastrointestinal Endoscopy
American Society of General Surgeons
American Society of Hematology
American Society of Neuroradiology
American Society of Plastic Surgeons
American Society for Surgery of the Hand
American Society for Therapeutic Radiology and Oncology
American Thoracic Society
American Urological Association
Contact Lens Association of Ophthalmologists
Joint Council of Allergy, Asthma, and Immunology
National Association of Social Workers
North American Spine Society
Society of Interventional Radiology
Society of Nuclear Medicine
Society of Thoracic Surgeons
The Endocrine Society

In reviewing this issue, and the necessary direct practice expense inputs required to provide conscious sedation in the non-facility setting, the RUC and its Practice Expense Advisory Committee (PEAC), determined that the following code structure for the stand-alone conscious sedation codes would be more appropriate:

99141 Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation; initial 15 minutes

99!X! each additional 15 minutes

99142 Sedation with or without analgesia (conscious sedation); oral, rectal, and/or intranasal; initial 15 minutes

991X2 each additional 15 minutes

This structure would lend to a more appropriate evaluation of physician work. In addition, the direct practice expense inputs (staff, medical supplies, and medical equipment) would primarily be assigned to the base code, with only the additional nurse time during the intra-service portion of the procedure included in the add-on codes.

RUC Recommendations

In summary, the RUC recommends the following changes to CPT for consideration in the *CPT 2005* cycle:

- 1. The CPT Editorial Panel should consider the addition of an Appendix in CPT to specifically identify the 229(+) CPT codes which inherently include conscious sedation, provided by the operating physician. This list may be updated annually as new CPT codes are added or to address codes where changes in practice lead to changes as to whether conscious sedation is inherently included. Addition or deletion of codes from the list must be approved by the RUC and submitted to the CPT Editorial Panel.**
- 2. The Appendix should include an explanatory note that “the inclusion of a procedure on this list does not prevent separate reporting of an associated anesthesia procedure/service (CPT codes 00100-01999) when performed by a provider (such as an anesthesiologist or CRNA) other than the operating physician.”**
- 3. Revision to the CPT codes for conscious sedation (99141 and 99142) and addition of new add-on codes to allow the reporting of conscious sedation on an increment of conscious sedation time during the procedure. A cross-reference directing the user to the new Appendix should also be added to these codes.**
- 4. Revision to the Anesthesia section notes in CPT to clarify that the reference to the conscious sedation codes only applies to physicians who are performing the procedure. A clarification should be made that when any physician, other than the physician performing the procedure, provides anesthesia services (conscious sedation or otherwise), the Anesthesia codes should be reported.**

List of CPT Codes that Inherently Include Conscious Sedation

CPT Code	Specialty Submitting Code	Descriptor
31500	ACCP/ATS	Intubation, endotracheal, emergency procedure
31615	ACCP/ATS	Tracheobronchoscopy through established tracheostomy incision
31622	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); diagnostic, with or without cell washing (separate procedure)
31623	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); with brushing or protected brushings
31624	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); with bronchial alveolar lavage
31625	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); with biopsy
31628	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); with transbronchial lung biopsy, with or without fluoroscopic guidance
31629	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); with transbronchial needle aspiration biopsy
31630	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); with tracheal or bronchial dilation or closed reduction of fracture
31631	AAP	Bronchoscopy (rigid or flexible); with tracheal dilation and placement of tracheal stent
31635	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); with removal of foreign body
31640	ACCP/ATS/AAP	Bronchoscopy (rigid or flexible); with excision of tumor
31641	ACCP/ATS/AAP	Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)
31643	ACCP/ATS/AAP	Bronchoscopy, (rigid or flexible); with placement of catheter(s) for intracavitary radioelement application
31645	ACCP/ATS/AAP	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)
31646	ACCP/ATS/AAP	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, subsequent
31656	ACCP/ATS/AAP	Bronchoscopy, (rigid or flexible); with injection of contrast material for segmental bronchography (fiberscope only)
32020	STS	Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)
32201	SIR	Pneumonostomy; with percutaneous drainage of abscess or cyst
33010	STS	Pericardiocentesis; initial
33011	STS	Pericardiocentesis; subsequent
33206	ACC	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial
33207	ACC	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular
33208	ACC	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular
33210	ACC	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)
33211	ACC	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)

33212	ACC	Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular
33213	ACC	Insertion or replacement of pacemaker pulse generator only; dual chamber
33214	ACC	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)
33216	ACC	Insertion of a transvenous electrode; single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator
33217	ACC	Insertion of a transvenous electrode; dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33218	ACC	Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator
33220	ACC	Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33222	ACC	Revision or relocation of skin pocket for pacemaker
33223	ACC	Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator
33233	ACC	Removal of permanent pacemaker pulse generator
33234	ACC	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular
33235	ACC	Removal of transvenous pacemaker electrode(s); dual lead system
33240	ACC	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator
33241	ACC	Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator
33244	ACC	Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by transvenous extraction
33249	ACC	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator
35470	SIR	Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel
35471	SIR	Transluminal balloon angioplasty, percutaneous; renal or visceral artery
35472	SIR	Transluminal balloon angioplasty, percutaneous; aortic
35473	SIR	Transluminal balloon angioplasty, percutaneous; iliac
35474	SIR	Transluminal balloon angioplasty, percutaneous; femoral-popliteal
35475	SIR	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
35476	SIR	Transluminal balloon angioplasty, percutaneous; venous
36870	SIR	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

43200	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43201	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance
43202	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with biopsy, single or multiple
43204	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices
43205	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with band ligation of esophageal varices
43215	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with removal of foreign body
43216	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43217	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43219	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent
43220	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)
43226	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire
43227	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
43228	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43231	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination
43232	ACG/AGA/ASGE	Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43234	ACG/AGA/ASGE	Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)
43235	ACG/AGA/ASGE/ASCRS	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43236	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance
43239	ACG/AGA/ASGE/ASCRS	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple
43240	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst

43241	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement
43242	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)
43243	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices
43244	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices
43245	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie)
43246	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube
43247	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body
43248	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire
43249	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)
43250	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43251	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43255	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method
43256	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)
43258	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

43259	ACG/AGA/ASGE	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination
43260	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43261	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
43262	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy
43263	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)
43264	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts
43265	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method
43267	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube
43268	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct
43269	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent
43271	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)
43272	ACG/AGA/ASGE	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43453	ACG/AGA/ASGE/ASCRS	Dilation of esophagus, over guide wire
43456	ACG/AGA/ASGE/ASCRS	Dilation of esophagus, by balloon or dilator, retrograde
43458	ACG/AGA/ASGE/ASCRS	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia
44360	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44361	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple
44363	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body
44364	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

44365	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44366	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44369	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44370	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)
44372	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube
44373	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube
44376	AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44377	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple
44378	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44379	ACG/AGA/ASGE/AAP	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)
44380	ACG/AGA/ASGE	Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44382	ACG/AGA/ASGE	Ileoscopy, through stoma; with biopsy, single or multiple
44383	ACG/AGA/ASGE	Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)
44385	ACG/AGA/ASGE	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44386	ACG/AGA/ASGE	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple
44388	ACG/AGA/ASGE/AAP	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	ACG/AGA/ASGE/AAP	Colonoscopy through stoma; with biopsy, single or multiple
44390	ACG/AGA/ASGE/AAP	Colonoscopy through stoma; with removal of foreign body

44391	ACG/AGA/ASGE/AAP	Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	ACG/AGA/ASGE/AAP	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
44393	ACG/AGA/ASGE/AAP	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44394	ACG/AGA/ASGE/AAP	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44397	ACG/AGA/ASGE/AAP	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)
44500	ACG/AGA/ASGE	Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)
44901	SIR	Incision and drainage of appendiceal abscess; percutaneous
45303	ACG/AGA/ASGE/ASCRS	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)
45305	ASCRS	Proctosigmoidoscopy, rigid; with biopsy, single or multiple
45307	ASCRS	Proctosigmoidoscopy, rigid; with removal of foreign body
45308	ASCRS	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309	ASCRS	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
45315	ASCRS	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317	ASCRS	Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320	ASCRS	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)
45327	ACG/AGA/ASGE	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)
45332	ACG/AGA/ASGE/ASCRS	Sigmoidoscopy, flexible; with removal of foreign body
45333	ACG/AGA/ASGE/ASCRS	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	ACG/AGA/ASGE	Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45337	ACG/AGA/ASGE	Sigmoidoscopy, flexible; with decompression of volvulus, any method
45338	ACG/AGA/ASGE/ASCRS	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45339	ACG/AGA/ASGE/ASCRS	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45340	ACG/AGA/ASGE	Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures
45341	ACG/AGA/ASGE	Sigmoidoscopy, flexible; with endoscopic ultrasound examination

45342	ACG/AGA/ASGE	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45345	ACG/AGA/ASGE	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)
45355	ACG/AGA/ASGE	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
45378	ACG/AGA/ASGE/ASCRS	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	ACG/AGA/ASGE/ASCRS	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380	ACG/AGA/ASGE/ASCRS	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381	ACG/AGA/ASGE	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
45382	ACG/AGA/ASGE/ASCRS	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45383	ACG/AGA/ASGE/ASCRS	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	ACG/AGA/ASGE/ASCRS	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	ACG/AGA/ASGE/ASCRS	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	ACG/AGA/ASGE	Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures
45387	ACG/AGA/ASGE	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
47011	SIR	Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages
48511	SIR	External drainage, pseudocyst of pancreas; percutaneous
49021	SIR	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous
49041	SIR	Drainage of subdiaphragmatic or subphrenic abscess; percutaneous
49061	SIR	Drainage of retroperitoneal abscess; percutaneous
50021	SIR	Drainage of perirenal or renal abscess; percutaneous
58823	SIR	Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)
92953	ACC	Temporary transcutaneous pacing
92960	ACC	Cardioversion, elective, electrical conversion of arrhythmia; external
92961	ACC	Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)

92973	ACC	Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)
92974	ACC	Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)
92975	ACC	Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography
92978	ACC	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)
92979	ACC	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)
92980	ACC	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
92981	ACC	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)
92982	ACC	Percutaneous transluminal coronary balloon angioplasty; single vessel
92984	ACC	Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)
92986	ACC	Percutaneous balloon valvuloplasty; aortic valve
92987	ACC	Percutaneous balloon valvuloplasty; mitral valve
92995	ACC	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel
92996	ACC	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)
93312	ACC	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93313	ACC	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
93314	ACC	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
93315	ACC	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93316	ACC	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only

93317	ACC	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only
93318	ACC	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to t
93501	ACC	Right heart catheterization
93505	ACC	Endomyocardial biopsy
93508	ACC	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization
93510	ACC	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
93511	ACC	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown
93514	ACC	Left heart catheterization by left ventricular puncture
93524	ACC	Combined transseptal and retrograde left heart catheterization
93526	ACC	Combined right heart catheterization and retrograde left heart catheterization
93527	ACC	Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)
93528	ACC	Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)
93529	ACC	Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
93530	ACC	Right heart catheterization, for congenital cardiac anomalies
93539	ACC	Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass
93540	ACC	Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries
93541	ACC	Injection procedure during cardiac catheterization; for pulmonary angiography
93542	ACC	Injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography
93543	ACC	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography
93544	ACC	Injection procedure during cardiac catheterization; for aortography
93545	ACC	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)
93555	ACC	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography

93556	ACC	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or use
93561	ACC	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)
93562	ACC	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
93571	ACC	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary pro
93572	ACC	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for pri
93609	ACC	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)
93613	ACC	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)
93615	ACC	Esophageal recording of atrial electrogram with or without ventricular electrogram(s);
93616	ACC	Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing
93618	ACC	Induction of arrhythmia by electrical pacing
93619	ACC	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted inducti
93620	ACC	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bund
93621	ACC	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separatel
93622	ACC	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for prim
93624	ACC	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia

93640	ACC	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implant
93641	ACC	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implant
93642	ACC	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming
93650	ACC	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement
93651	ACC	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination
93652	ACC	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia

**Central Venous Access Codes that Inherently Include Conscious Sedation
Approved in May 2003**

CPT Code	Description
36555	Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age
36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age
36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older
36560	Insertion of tunneled centrally inserted central venous access device with subcutaneous port; under 5 years of age
36561	Insertion of tunneled centrally inserted central venous access device with subcutaneous port; age 5 years or older
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36565	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump, (eg, Tesio type catheter);
36566	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, under 5 years of age
36570	Insertion of peripherally inserted central venous access device with subcutaneous port; under 5 years of age
36571	Insertion of peripherally inserted central venous access device with subcutaneous port; age 5 years or older
36576	Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36582	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access
36583	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access
36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access
36590	Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion

AMA/Specialty Society RVS Update Committee Practice Expense Subcommittee Report – April 24, 2003

The Practice Expense Subcommittee met during the April 2003 RUC meeting to continue its work on the allocation of physician time components, and discuss a mechanism of adding a non-facility practice expense component. The following Subcommittee members participated: Doctors Levy (Chair), Blankenship, Gage, Gerety, Lichtenfeld, McCaffree, Moran, Rich, and David Hitzeman, DO and Tony Hamm, DC.

Reallocation of Physician Time Components – Status of 227 CPT Codes

At the February 2002 RUC meeting, AMA staff identified 227 non-RUC surveyed 010 and 090 day global CPT codes which have only total time within CMS's database. The PEAC has assigned post operative practice expense inputs according to existing codes through RUC and CMS's physician time components. These 227 CPT codes apparently were cross-walked by CMS in some unknown manner. CMS staff have not been able to explain the methodology for which these codes had been cross-walked. In addition, since these codes did not have any time components used for practice expense purposes, only total time, AMA staff to sent the list of the 227 codes to specialty societies to ask them to address the following question in regard to these codes:

Do you agree that the physician time is valid?

If the answer to this question is yes, the RUC asked the specialty societies to allocate the total physician time into the various time components of pre-service, intra-service, and immediate post service time periods, and include the number and level of post-operative hospital and office visits.

If the answer to the question is no, the RUC 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 the physician time and would have no bearing on physician work.

At the RUC meeting in February 2003, in an effort to decrease the administrative burden on the specialties, and to clearly distinguish the codes in the RUC database, the practice expense subcommittee and the RUC made the following recommendations:

For this exercise, the RUC should accept a methodology for reducing CMS total physician time for those codes for which a specialty society who predominately performs the service, believes it is appropriate, by accepting a cross-walk to a similar family of codes that have RUC surveyed times, and/or may use an expert panel.

These codes for this exercise will be "clearly identified within the RUC database as not being allowed to be considered when making work recommendations. This would apply not only for the physician time components from the surveys, but other information contained on the summary of the recommendation forms (ie, the vignette and descriptors of work), would state "DO NOT USE TO VALIDATE FOR PHYSICIAN WORK".

Subcommittee members at this meeting reiterated their concern that specialties may use the physician time allocations from this process to alter work values any time in the future. The subcommittee believed that specialties may try to use their survey results and allocations for the next 5 year review, and believed that this should be prevented. The subcommittee was reminded that the initial purpose of the time allocations was to help the PEAC determine clinical staff labor practice expense time, as it is driven by physician time.

Approved at the April 2003 RUC Meeting

In addition, Subcommittee members were concerned that by changing total physician time through this survey process, it may alter the practice expense specialty pools. A CMS representative explained that if the total time for a code increases for any reason, the size of the specialty practice expense pools may increase, resulting in more practice expense dollars being allocated to those pools. Subcommittee members believed then that total time for the 227 codes shouldn't be submitted to CMS at all, but that only the allocations and surveyed physician time components that would facilitate the PEAC's practice expense refinement should be forwarded. Subcommittee members understood that the PEAC needed to know if there are post operative visits involved with the service, and that if the service is performed in the non-facility setting, the physician intra-service time, when an assistant is required. No additional physician time information was necessary for the PEAC process. The Practice Expense Subcommittee recommends that:

The RUC accept the physician time components presented as needed to facilitate the PEAC's process. In addition, these codes will be asterisked in the RUC database, and the total time should not be entered into the CMS database for their practice expense methodology.

Mechanism for Adding a Non-Facility Practice Expense Component

At the February 2003 Practice Expense Subcommittee meeting, members discussed the need for a mechanism for establishing a non-facility practice expense component for those codes that have been historically performed in the facility setting. An example would be a new technology that enables a procedure to be moved from an ambulatory service center to an office based setting. The subcommittee agreed that there should be a mechanism to establish a non-facility practice expense as practice patterns change. Currently, CMS determines whether there is non-facility or facility practice expenses, and CMS generally believes that specialties should decide whether they want practice expenses for either setting.

At the March 2003 PEAC meeting, specialty societies sought in-office practice expense inputs for some percutaneous endoscopic procedures that have been historically hospital based procedures. These procedures are currently only priced in the facility setting, and there would be significant expenses incurred if the procedure was to be performed in the non-facility setting. The most significant issue raised during the PEAC meeting was with this ability to perform these in-facility procedures in an office setting, will CMS create a comparable shift of funds from the Part A budget to the Part B budget to compensate for the shift in practice. Unfortunately, CMS does not have the ability by law to shift money from Part Medicare Part A to Part B.

At this Subcommittee meeting, concern was expressed that any procedure that requires the use of expense disposables and/or expensive equipment that is shifted from the facility to a physician's office, without a comparable shift of funds from Part A to B, may create huge impacts throughout the current practice expense methodology. In addition, there may be disincentives to perform services in a particular setting, and it may be quite difficult to price many of these supplies in a different site of service.

CMS does not intend for payment policy to drive coverage policy, however, without non-facility pricing, physician services may not move to the more preferred, or appropriate, site of service. It is also believed by the Subcommittee members that the total practice expense dollars has decreased over time due to actions of congress and there hasn't been any comparable shift of funds due to changes in the sites of service. The Subcommittee summed up the discussion that there is no new money to be allocated for these changes in sites the sites of service and for now, it is a philosophical discussion that can't be fixed without a major overall of the healthcare system.

Practice Expense RVUs that are Greater than Work RVUs

In a separate issue, the Subcommittee discussed the fact that there are several codes that have practice expense RVUs that are greater than the Work RVUs. Specifically, there are some E/M codes where the practice expense components have shifted from being below the work RVUs to being above the them. Doctor McCaffree raised the issue because these codes are high volume codes, and they are used for many 000, 010, and 090 day codes. Other Subcommittee questioned what the ratio is, when looking at total RVUs, of the practice expense RVUs to work RVUs over time, believing that as we shift sites of service from the facility to the non-facility, there is ever increasing practice expense RVUs. It was determined by the Subcommittee that additional information and data is necessary, and Doctor McCaffree will research these issues and report back to the group at its next meeting.

**AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
Thursday, April 24, 2003, 12:00 pm – 1:30 pm**

Members present: Doctors William Gee (Chair), Norman Cohen, Charles Koopmann, Gregory Przybylski, Richard Tuck, Susan Strate, Paul Wallner, Richard Whitten, and Ms. Nelda Spyres, LCSW

Review of Election Procedures

There are nine “Any Other” Rotating Seat candidates and five Internal Medicine Rotating Seat Candidates. As a result Doctor Hoehn, RUC Chair, has determined that the amount of time for candidates to present their credentials to the RUC should be reduced from two to one minute. Candidates should use the following question as a guideline for their presentation, “What can you contribute to the RUC?”

Doctor Hoehn requested that the Administrative Subcommittee consider the following questions:

- 1) Should candidates be allowed to make their presentations for candidacy to the RUC at times that differed from the previously specified time?
- 2) Should the time of the election be changed to accommodate candidates that will not be able to present at the specified time?

The subcommittee determined that candidates are only allowed to present their bid for candidacy at the specified time. Additionally, the subcommittee affirmed the election time as Saturday, April 26, 2003, at 7:00 am. Candidates who are not present at that time, may request that someone speak for them, if they wish. Copies of the Election Rules and Procedures will be distributed at the meeting.

Discussion of the 2005 Five-Year Review

The Subcommittee had a generic discussion regarding the next Five-Year Review. A suggestion was made that the Subcommittee consider reviewing all codes that have only been assigned Harvard time (approximately 3000 RUC codes). A Subcommittee member argued that specialties should not be required to survey if they agree with the Harvard time. It was also recommended that the Subcommittee discuss objective ways to revalue codes, that would not only identify undervalued codes, but also over-valued codes. In addition, the Subcommittee discussed that families of codes should be reviewed as opposed to reviewing codes on an individual basis. The subcommittee agreed that further discussion is necessary and that dialogue with CMS should begin on methods to use to identify mis-valued codes for the next Five-Year Review.

Consideration of “Rolling Five-Year Review”

Doctor Florin, presented the American Academy of Pain Medicine letter submitted to Doctor Hoehn, with support of three RUC members. The letter and the attached proposal outlined the rationale, scope of the project, projected impact and details of the filtering process in reviewing work values for families of codes that have rank order anomalies. This letter suggested that the RUC review such codes on a periodic basis, in advance of the Five-Year review to facilitate the process. The committee considered whether it should compose a letter to CMS requesting to shorten the interval for the Five-Year review of existing CPT codes.

CMS clarified its position that they are not supportive of a rolling review process. In addition, **the Subcommittee recommends that the duration between reviews should be maintained at five year intervals.**

Approved at the April 2003 RUC Meeting

The Subcommittee agreed that the RUC should prevent the creation of rank order anomalies for new and revised codes. To prevent the problems of distorted relativity within the family, the families of codes should be presented simultaneously to the RUC.

Several Subcommittee members spoke in favor of this idea. Sherry Smith pointed out that the families of codes should be identified at the CPT Editorial Panel Meeting in order for all specialties to survey or comment all codes within the associated family. One possible challenge of prospectively identifying rank order anomalies is that many of the anomalies may not be recognized until the codes have been surveyed. In addition, CMS asked the Subcommittee to consider the possibility that this proposed procedure may cause incentives to revise codes at CPT in order to increase the value of a family of codes. The Subcommittee recommends the following:

Going forward with review of new and revised codes, societies will be encouraged, where applicable, to address at the same time, not only the individual new or revised codes, but also anticipated resulting problems with a related family of codes.

The Subcommittee suggested that this action be added in the Instructions to Specialty Societies for Developing Work Relative Value Unit Recommendations and be communicated to the specialty societies.

**RUC Research Subcommittee
April 24, 2003**

The following Subcommittee members attended the meeting: Doctors James Borgstede, (Chair), James Blankenship, Michael Bishop, Melvin Britton, John Derr, John Mayer, Bernard Pfeifer, J. Baldwin Smith, Robert Zwolak, and Don Williamson, OD.

ZZZ Code Definition Change

As a result of the change in the definition of ZZZ codes, the RUC asked specialty societies to identify any ZZZ codes where the physician work or practice expense may be affected by the definition change. A total of 69 codes were resubmitted from four specialty societies and the subcommittee discussed how these codes should be reviewed by the RUC and PEAC. Doctor Rudolf clarified the CMS statement in the Federal Register that specified the change in the ZZZ definition. It was the intent of CMS that the definition change was made primarily to allow specialty societies to recognize additional practice expenses. However, when these codes would be reviewed for practice expense, the practice expense of the associated base codes would need to be reviewed as well. It was not the intent of CMS that the physician work for these codes be reviewed outside of the five-year review process. The subcommittee agreed that these codes could be reviewed by the PEAC for refinement of the PE inputs and adopted the following recommendation:

Review ZZZ codes and the associated base code that may be affected by the definition change as part of the next five-year review. (To begin in Fall, 2004)

Pre Service Time Period Definition

During the last RUC meeting, the RUC held a discussion regarding the pre-service time period definition of physician work. As a result of JCAHO requirements, a history and physical (H&P) must be performed within 7 days of surgery. Since the global period starts the day before surgery, the RUC has requested clarification from CMS if such a visit could be separately billable. Doctor Rudolf stated that it was CMS's understanding that a H&P is usually included in the pre-service work of 90 day global procedures and that such visits should not be separately billed, however, CMS does not have specific policy that would automatically deny payments for E/M visits that occur between the decision for surgery and the start of the global period. Doctor Zwolak stated that the pre-service work included in the 90 day codes does not usually include a H&P and the description of pre-service work should be examined to see if it has been included in RUC reviewed codes.

The subcommittee also discussed the differences between the RUC and CMS definitions of pre-service time for 000 and 010 day global procedures. CMS defines the pre-service time period for these two global periods as beginning the day of surgery, but the RUC defines the pre-service period for 000 and 010 day global the same as 90 day global and begins the global period on the day before surgery, rather than the day of the surgery. The Subcommittee was very concerned with altering the RUC definition since it could lead to arbitrary reductions in these codes. To make a more informed decision the subcommittee would first like to know the number of 000 and 10 day codes that the RUC has reviewed using the current pre-service

time definition and then possibly also look at the description of pre-service work to see if it includes work that would typically occur before the day of the procedure but was included in the work valuation. After the subcommittee reviews this information it would discuss the issue further. Some workgroup members suggested possibly requesting CMS to change its definition since the assignment of global periods for codes is somewhat arbitrary and there is not a large difference between 90 day and 10 day procedures in terms of pre-service physician work.

The Subcommittee passed the following motion:

Identify the number of 000 and 10 day global period codes that the RUC has reviewed using the current pre service definition so the subcommittee can review this information at the September, 2003 RUC meeting.

Inclusion of IWPUT in the MPC List

The Research Subcommittee was requested to discuss the possibility of including in the MPC list the IWPUT for each of the codes on the MPC list. A number of workgroup members were concerned that the inclusion of IWPUT calculations would lead to publishing IWPUT figures that may be inaccurate, especially for calculations based on Harvard time data. In addition some workgroup members felt that IWPUT may only be applicable for 90 day codes and publishing IWPUT calculations for all other global period codes may lack validity.

Since IWPUT is used by some RUC members when evaluating codes, the Subcommittee agreed that the IWPUT should be calculated for the MPC codes with RUC times provided that the specialties and the Research Subcommittee would have an opportunity to comment on the inclusion of IWPUT on the MPC list.

The Research Subcommittee passed the following motion:

The IWPUT for all Type A codes on the MPC list should be calculated for review by the Research Subcommittee. This would involve first allowing specialties an opportunity to comment on each code and indicate if the IWPUT should be listed on the MPC. The data source and IWPUT calculation formula should also be provided to the RUC.

**RUC Anesthesia Workgroup
April 24, 2003**

The following members of the Anesthesia workgroup participated: Doctors John E. Mayer, (Chair), Norman Cohen, John Derr, Jr., John Gage, Bill Gee, Keith Horvath, Charles Koopmann, J. Leonard Lichtenfeld, Greg Przybylski, Sandra Reed, Richard Whitten, and Robert Zwolak.

The workgroup met to continue its review of the Anesthesia five-year review issue. The workgroup began with Doctor Cohen, ASA requesting: that the workgroup develop a statement that could be submitted to the RUC for approval that clarified the workgroup's conclusions regarding the analysis of the 19 anesthesia codes. Such a clarification would be responsive to the CMS request and would not require the workgroup to reevaluate each of the 19 anesthesia codes.

The workgroup reviewed the minutes of the April 14, 2003 workgroup conference call and the focus was on the seven reasons the workgroup listed for why the workgroup did not previously recommend extrapolation of the analysis of the 19 anesthesia codes. A workgroup member felt that the first reason listed, pertaining to the structural differences between the anesthesia system and the RBRVS, was worded too strongly. It was suggested that the workgroup recognized the significant differences between the two systems and felt that a comparison between the two systems was difficult, however, the workgroup did the best translation that could be achieved.

Request from CMS Administrator Scully for the RUC to examine the adequacy of work values for all anesthesia codes.

The workgroup then discussed in detail whether or not the workgroup has examined enough data that would warrant a change in anesthesia work values and ultimately in the anesthesia conversion factor. A number of workgroup members commented that a considerable amount of additional work, time, and expenses would be required for ASA and the RUC. This would involve the review of a much larger number of anesthesia codes before the workgroup could recommend to the RUC a definitive statement on changing all anesthesia work values. Other workgroup members did not know of any other method short of reviewing all anesthesia codes due to the differences between the two systems.

The workgroup considered a variety of possible responses to the CMS request and they all included an explanation of the workgroup's inability to recommend extrapolation to all anesthesia codes. To enable the workgroup to make a more definitive recommendation to the RUC that would affect all anesthesia work values would require a great deal of additional time, effort, and expense and it was unclear if the RUC would be able to attempt such an undertaking in the 2003 timeframe mentioned in the CMS letter. Also, it was unclear if ASA would be willing or able to participate in such a large project.

Doctor Cohen requested the workgroup to examine a proposed statement that could be forwarded to the RUC for approval. This would state that the workgroup analysis of the 19 anesthesia codes was applicable to more than the 19 surgical codes but less than the total of all surgical codes reportable under the nineteen anesthesia codes. Additionally the workgroup

could then recommend to the RUC that it could not reach consensus on the larger issue of extrapolation to all anesthesia codes.

Two workgroup members representing Vascular Surgery and Neurosurgery stated that in reviewing the statements for the vascular and neurosurgery codes included in the analysis, they concluded that only the individual surgery code selected for each anesthesia code could be included in the analysis. For example, for the four vascular surgery codes, the workgroup report from last year stated that in three cases only the single surgery code for each anesthesia code could be included due to the dissimilarities among the surgical codes within each family. For the fourth code 00350, the workgroup report states that the results could be extrapolated to the other surgical codes in the family, however, it was not clearly understood by the vascular surgery representative that such a statement would have implications beyond the single anesthesia code. When the workgroup developed its report, all 30 surgical codes in the family were not examined and if the intent is to use the analysis to apply to all anesthesia codes, then a more careful examination of the 30 surgical codes would need to take place. Therefore, based on a better understanding of the methodology, the analysis of the four vascular anesthesia codes should only be based on the four associated vascular surgical codes and not all the vascular surgical codes in each family.

A number of the workgroup members agreed that they were uncomfortable expanding the analysis beyond the 19 surgical codes associated with each of the anesthesia codes. Even if the workgroup was able to reexamine each of the 19 anesthesia codes and was able to specify additional surgical codes to be included in the analysis, the workgroup did not feel that it would be any better able to make a recommendation to extrapolate those results to all anesthesia codes. **Therefore, the workgroup concluded that the workgroup's previous analysis should only apply to the 19 anesthesia codes and the associated 19 surgical codes.**

The WG recommends to the RUC the following:

- **The RUC position is that the 5 year review has been completed.**
- **The RUC anesthesia workgroup analysis only applies to the 19 anesthesia codes and associated 19 surgical codes.**
- **The WG recommends to the RUC that the following list of structural differences between the anesthesia coding system and the remainder of the physician coding system, which contribute to the difficulties in making extrapolations to the entire set of anesthesia services, be forwarded to CMS administrator Scully in response to his letter of February, 2003.**

1. The RUC felt that a comparison between two different systems; the time based anesthesia system and the RBRVS system where time is fixed for each code, did not allow for a valid comparison.
2. The vignette selected may not have been accurate or the selected surgical code was not representative of the entire family of surgical codes.
3. An analysis of a single anesthesia code based on a single surgical code was insufficient when the anesthesia code covers a large number of surgical codes. The workgroup indicated for each anesthesia code its confidence in the number of surgical

codes that should be included in the analysis and in many cases the extrapolation was limited to select surgical codes.

4. For those anesthesia codes that cover a large number of surgical codes, there was a concern that smaller families would be needed due to the variability in intensity and time among the surgical codes. Due to the variability in time and intensity the analysis based on a single surgical code could not always be applied to all surgical codes in the anesthesia family. This reasoning also applied to extrapolating the results of the 19 anesthesia codes to all anesthesia codes due to the variability in the associated surgical codes.
5. The RUC was not convinced based on the data presented that the results of the 19 anesthesia code analysis could be extrapolated to the remainder of the anesthesia codes. A workgroup member attributed this unwillingness to extrapolate due to RUC not having the statistical confidence to determine if extrapolating the analysis of the 19 anesthesia codes to all anesthesia codes would be valid.
6. Although the RUC recommended extrapolation in the first five-year review the RUC did not make a similar recommendation in the second five-year review. This was because there has been an evolution in the RUC process where now the RUC uses new data such as IWPUT, and has better physician time data and better understanding of intensity. Also, the RUC had a much more detailed methodology for reviewing the anesthesia codes than it did in the first five year review.
7. There was a concern that the 19 selected anesthesia codes may not be the most representative anesthesia codes. Although these are the highest volume codes there was concern whether this was the right type and number of anesthesia codes. This concern is closely related to the other concerns about basing a change in value for over 200 codes based on an analysis of only 19 codes. Specifically, there was a concern that 4 of the 19 surgical codes selected were vascular surgery codes and this seemed to create an overemphasis on vascular surgery procedures, possibly skewing the analysis. Given the wide range of intensity and time among the surgical codes within each of the 19 families, there was a concern that there could also be great variations between the 19 anesthesia codes and all other anesthesia codes. It was suggested by a workgroup member that there may need to be additional anesthesia codes included in the analysis in order to support extrapolation from a small subset of codes to all other anesthesia codes.

June 27, 2003

Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Hubert Humphrey Building, Room 314-G
200 Independence Ave., SW
Washington, D.C. 20201

Dear Mr. Scully:

I am writing in response to your letter requesting the AMA/Specialty Society RVS Update Committee (RUC) continue its review of anesthesia work values. The RUC reconstituted the anesthesia Workgroup to reexamine its previous recommendation and analysis. The Workgroup developed a report that included three new recommendations. The full RUC reviewed the Workgroup report and approved the following conclusions and recommendations:

- **The RUC position is that the 5 year review has been completed.**
 - **The RUC anesthesia workgroup analysis only applies to the 19 anesthesia codes and associated 19 surgical codes.** (This pertains to the RUC recommendations and analysis sent to CMS in 2002)
 - **The Workgroup recommends to the RUC that the following list of structural differences between the anesthesia coding system and the remainder of the physician coding system, which contribute to the difficulties in making extrapolations to the entire set of anesthesia services, be forwarded to you in response to your letter of February, 2003.**
8. The RUC felt that a comparison between two different systems; the time based anesthesia system and the RBRVS system where time is fixed for each code, did not allow for a valid comparison.
 9. The vignette selected may not have been accurate or the selected surgical code was not representative of the entire family of surgical codes.
 10. An analysis of a single anesthesia code based on a single surgical code was insufficient when the anesthesia code covers a large number of surgical codes. The workgroup indicated for each anesthesia code its confidence in the number of surgical codes that should be included in the analysis and in many cases the extrapolation was limited to select surgical codes.
 11. For those anesthesia codes that cover a large number of surgical codes, there was a concern that smaller families would be needed due to the variability in intensity and time among the surgical codes. Due to the variability in time and intensity the analysis based on a single surgical code could not always be applied to all surgical codes in the anesthesia family. This reasoning also applied to extrapolating the results of the 19 anesthesia codes to all anesthesia codes due to the variability in the associated surgical codes.

-2-

12. The RUC was not convinced based on the data presented that the results of the 19 anesthesia code analysis could be extrapolated to the remainder of the anesthesia codes. A workgroup member attributed this unwillingness to extrapolate due to RUC not having the statistical confidence to determine if extrapolating the analysis of the 19 anesthesia codes to all anesthesia codes would be valid.

Approved at the April 2003 RUC Meeting

13. Although the RUC recommended extrapolation in the first five-year review the RUC did not make a similar recommendation in the second five-year review. This was because there has been an evolution in the RUC process where now the RUC uses new data such as IWPUT, and has better physician time data and better understanding of intensity. Also, the RUC had a much more detailed methodology for reviewing the anesthesia codes than it did in the first five year review.
14. There was a concern that the 19 selected anesthesia codes may not be the most representative anesthesia codes. Although these are the highest volume codes there was concern whether this was the right type and number of anesthesia codes. This concern is closely related to the other concerns about basing a change in value for over 200 codes based on an analysis of only 19 codes. Specifically, there was a concern that 4 of the 19 surgical codes selected were vascular surgery codes and this seemed to create an overemphasis on vascular surgery procedures, possibly skewing the analysis. Given the wide range of intensity and time among the surgical codes within each of the 19 families, there was a concern that there could also be great variations between the 19 anesthesia codes and all other anesthesia codes. It was suggested by a workgroup member that there may need to be additional anesthesia codes included in the analysis in order to support extrapolation from a small subset of codes to all other anesthesia codes.

The complete report of the workgroup is attached. I appreciate your continued consideration of RUC recommendations and I trust that you will find that these final RUC recommendations sufficiently address your request for additional RUC review. As I begin my term as RUC chair, I look forward to working with you and the outstanding CMS representatives that attend the RUC meetings.

Sincerely,

William L. Rich III, MD

cc: RUC Members
Attachment