

**AMA/Specialty RVS Update Committee  
Meeting Minutes  
April 27- May 1, 2005**

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Thursday, April 28, 2005 at 9:30 am. The following RUC Members were in attendance:

William Rich, MD (Chair)	J. Leonard Lichtenfeld, MD
Bibb Allen, Jr., MD*	Scott Manaker, MD
Dennis Beck, MD*	John E. Mayer, Jr., MD
James Blankenship, MD	Bill Moran, Jr., MD
James P. Borgstede, MD	Bernard Pfeifer, MD
Neil H. Brooks, MD	Gregory Przybylski, MD
Joel V. Brill, MD*	Sandra Reed, MD*
Ronald Burd, MD*	Chester W. Schmidt, Jr., MD
Norman A. Cohen, MD	Daniel Mark Siegel, MD
James Denny, MD*	J. Baldwin Smith, III, MD
John Derr, Jr., MD	Peter Smith, MD*
Mary Foto, OT	Susan M. Strate, MD
John O. Gage, MD	Trexler Topping, MD
William F. Gee, MD	Arthur Traugott, MD*
David F. Hitzeman, DO	Richard Tuck, MD
Peter Hollmann, MD	James C. Waldorf, MD*
Charles F. Koopmann, Jr., MD	Richard W. Whitten, MD
M. Douglas Leahy, MD*	Maurits J. Wiersema, MD
Barbara Levy, MD	Robert M. Zwolak, MD
Brenda Lewis, DO*	

\*Alternate

II. Chair's Report

Doctor Rich made the following announcements:

- Doctor Rich discussed the following:
  - Financial Disclosure Statements must be submitted to AMA staff prior to presenting. If a form is not signed prior to your presentation, you will not be allowed to present.
  - The September 2005 meeting is reserved for the Five-Year Review and the few issues that come out of the June CPT meeting.
  - In the course of reviewing new/revised codes, the RUC presumes that the current valuation of a family is correct. However,

specialties may present compelling evidence to convince the RUC that an increase is warranted. The specialty does not have to wait for a five-year review to accomplish this if the RUC agrees with the compelling evidence. This is part of instructions and has occurred several times throughout our new/revised code process. RUC members should not be confused about this because of the proximity to the Five-Year Review. However, the RUC members should note that the compelling evidence standards are the same, and the same rigor should be used when considering an increase to a family of codes as would be used in the Five-Year Review.

- Doctor Rich welcomed the CMS Staff attending the meeting, which include:
  - Edith Hambrick, MD, CMS Medical Officer
  - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
  - Ken Simon, MD, CMS Medical Officer
  - Pam West, PT, CMS Health Insurance Specialist
  
- Doctor Rich welcomed the following Medicare Contractor Medical Directors:
  - Richard Baer, MD, Region V Intermediary Medical Director, Part A Specialty: Psychiatry AdminaStar Federal, Inc.
  - Stephen Boren, MD, Carrier Medical Director Specialty: Emergency Medicine Wisconsin Physician Services Insurance Corp. (WPS)
  - William Mangold, MD
  
- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting are:
  - James Anthony, MD
  - Katherine Bradley, PhD, RN\*
  - Joel Brill, MD\*
  - Neal Cohen, MD\*
  - Richard Dickey, MD
  - Thomas Felger, MD
  - Gregory Kwasny, MD
  - Peter McCreight, MD
  - Bill Moran, MD\*
  - Tye Ouzounian, MD
  - James Regan, MD
  - Anthony Senagore, MD

*\*official representatives at the RUC meeting to assist Doctor Moran with input*

- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee #1

Norman Cohen, MD, Chair  
Thomas Felger, MD\*  
William Gee, MD  
Emily Hill, PA-C  
Charles F. Koopman, Jr., MD  
Scott Manaker, MD, PhD\*  
Bernard Pfeifer, MD  
Chester W. Schmidt, Jr., MD  
Richard Whitten, MD

Facilitation Committee #2

Meghan Gerety, MD, Chair  
Neil Brooks, MD  
Mary Foto, OTR\*  
John Gage, MD  
John Mayer, Jr., MD  
Charles Mick, MD  
Daniel Mark Siegel, MD\*  
J. Baldwin Smith, III, MD  
Richard Tuck, MD

Facilitation Committee #3

Trexler Topping, MD, Chair  
Joel Brill, MD\*  
James Blankenship, MD  
Neal Cohen, MD\*  
Jonathan Cooperman, PT, DPT, MS, JD  
John Derr, Jr., MD  
Peter Hollmann, MD  
Gregory Przybylski, MD\*  
Samuel D. Smith, MD  
Arthur Traugott, MD

Facilitation Committee #4

Barbara Levy, MD, Chair  
Dennis Beck, MD  
James Borgstede, MD\*  
David Hitzeman, DO  
J. Leonard Lichtenfeld, MD  
Bill Moran, MD\*  
Katherine Bradley, PhD, RN\*  
Susan Strate, MD  
Robert Zwolak, MD

\* Current Practice Expense Review Committee (PERC) member or former Practice Expense Advisory Committee (PEAC) member

- The following individuals were observers at the February 2005 meeting:

FirstName	LastName	Society
Andrea	Boon	American Association of Electrodiagnostic Medicine
Michael	Chaglasian, OD	American Optometric Association
John	Conte, MD	Society of Thoracic Surgeons
Laura Saul	Edwards	American Academy of Dermatology
Peggy	Eiden	American Academy of Dermatology
Neal	Freeman, MD	American Academy Ophthalmology
Christopher	Gallagher	American College of Cardiology
Matthew	Garoufalis, DO	American Podiatric Medical Association
Denise	Garris	American College of Cardiology
Lanny	Garvar, DMD	American Association of Oral and Maxillofacial Surgeons
Catherine	Gottfred, PhD	American Speech-Language Hearing Association
Katie	Hanson	American Association of Electrodiagnostic Medicine
Robert	Harris, MD	American College of Obstetricians and Gynecologists
Kerry	Hunt	American College of Physicians
Richard	Kagan, MD	American Burn Association
Jeffrey	Kant, PhD	College of American Pathologists
Kirk	Kanter, MD	Society of Thoracic Surgeons
Margaret	Klys	American Osteopathic Association
Wayne	Koch, MD	American Academy of Otolaryngology - Head and Neck Surgery
Andrew	Ku, MD	American Society of Neuroradiology
Tim	Malisch	American Society of Neuroradiology
Gilbert	Martin, MD	American Academy of Pediatrics
Robert	McCaffrey, PhD	American Psychological Association
Najeeb	Mohideen, MD	American Society for Therapeutic Radiology and Oncology
Richard	Molteni, MD	American Academy of Pediatrics
David	Pariser, MD	American Academy of Dermatology
Brian	Parsley, MD	American Association of Hip and Knee Surgeons
Bernard	Patashnik	Consultants
Paul	Pessis	American Speech-Language Hearing Association
Neil	Pliskin, MD	American Psychological Association
Christine	Ren	American Society for Bariatric Surgery
Robert	Schwarzberg, MD	American College of Cardiology
James	Scroggs	American College of Obstetricians and Gynecologists
Jason	Scull	Infectious Diseases Society of America
Bruce	Smith, PhD	American Psychological Association
Frank	Spinosa, DPM	American Podiatric Medical Association

FirstName	LastName	Society
Albert	Strunk, MD, JD	American College of Obstetricians and Gynecologists
Nancy	Swigert	American Speech-Language Hearing Association
Ronald	Szabat	American Society of Anesthesiologists
George	Taler, MD	American Academy of Home Care Physicians
Raymond	Tubbs, DO	College of American Pathologists
Patrick	Turski, MD	American Society of Neuroradiology
Diane	Wallis, MD	American College of Cardiology
Paul	Wallner, DO	American Society for Therapeutic Radiology and Oncology
Mike	Westerveld, PhD	American Psychological Association
W. Patrick	Zeller, MD	American Association of Clinical Endocrinologists

- Doctor Rich thanked the following RUC members, who are rotating off, for their dedication to the RUC:
  - Maurits J. Wiersema, MD
  - Neil H. Brooks, MD
  - Robert M. Zwolak, MD
  - William Gee, MD
  
- Stephen Zuckerman and Robert Berenson from The Urban Institute discussed the data presented to MedPac on RVU and volume changes in the first ten years of the Physician Fee Schedule. The review showed:
  - A relatively small share of RVUs reflect Harvard-assigned RVUs
  - The Five-Year Review increased more RVUs than it decreased, and the increases, especially in 2002, were larger
  - RVU growth is driven by service volume for some types of service and RVU changes for others
  - New codes shift RVUs away from E/M, but the practice expense RVUs offset this phenomenon
  
- A RUC member commented that it would be interesting to find out where and who delivers E/M services now as opposed to 1992.

### III. Washington Update

Sharon McIlrath and Kurt Gillis, PhD, updated the RUC on the issues surrounding the SGR. Ms. McIlrath reviewed the annual Trustees Report. The Trustees Report indicated that:

- spending on services included that the SGR increased by 12% in 2004. This indicates that volume and intensity per beneficiary increased by 7 percent
- spending on hospital outpatient department showed an increase of 14% and Part A growth was lower than anticipated
- projected physician updates of -4% to -5%

The preferred solution is to eliminate the SGR. However, CBO estimates this to cost \$154 billion. A bill to eliminate the SGR is currently being worked on, however, no specific action has been taken.

Ms. McIlrath requested that the RUC review the 2004 Medicare utilization data and e-mail AMA staff with any comments and general observations in two weeks. Over two years ago the RUC reviewed similar reports and general themes identified were technological innovations, practice parameters in quality improvement and shifts in site of care.

Ms. McIlrath summarized the current status of the SGR and MEI for members of the RUC. Kurt Gillis, PhD, reviewed data tables examining spending related to:

- Laboratory tests
- Non-Medicare Fee Schedule services
- Prescription drugs covered by Part B in 2004 paid for under the SGR
- Lab tests paid for under the clinical lab fee schedule
- Imaging
- Volume and intensity per Medicare beneficiary/enrollee

A RUC member questioned CMS regarding issues surrounding expansion of coverage by carriers. Has the agency given any thought on how to review its own data to share the increasing utilization of existing technology data with the AMA or specialty societies so that we can understand what projected costs and utilization may be in specific populations?

Doctor Ken Simon responded that the agency has been examining ways to determine the value for services in which CMS provides payment and whether these services actually improve the outcome for patients receiving them.

IV. Directors Report

Sherry Smith announced:

- The calendar of meeting dates and locations
- Doctors John O. Gage, MD and J. Leonard Lichtenfeld, MD have been appointed to the RUC for another three years
- Doctors James B. Regan, MD, will be the new representative for the American Urological Association (AUA) and Thomas A. Felger, MD will be the new representative for the American Academy of Family Physicians (AAFP) at the September 2005 meeting
- The Five-Year Review workgroups will meet at lunch for an orientation session

V. Approval of Minutes for the February 3-5, 2005, RUC meeting

**The RUC reviewed the minutes and accepted them as presented.**

VI. CPT Editorial Panel Update

Doctor Peter Hollmann briefed the RUC that there will be a conference call of the CPT Executive Committee for important issues from the April RUC meeting. RUC issues will be addressed at this conference call in order to be included in the 2006 CPT publication.

VII. CMS Update

Doctor Ken Simon briefed the RUC that the CMS administrator, Mark McClellan, has indicated that the focus of the agency is developing pay-for-performance initiatives. CMS initiated the pay-for-performance workgroup in 2005.

A RUC member questioned Doctor Simon if specialty societies will work together with CMS to develop what is important to the specialty society along with what is important to CMS regarding pay-for-performance indicators. Doctor Simon responded that CMS will most likely conduct public forums to seek input from various specialty societies to define pay-for-performance indicators.

VIII. CMD Update

Doctor William Mangold emphasized the point regarding expansion of coverage by carriers. When there is sufficient data and supporting literature one opts for a National Coverage Decision (NCD), when it is a close call one opts for a Local Coverage Decision (LCD). Individual input is a large part of what research CMDs perform and a necessity to CMD decision-making. Many RUC members are contacted for help regarding decisions on these issues, which are increasing exponentially.

Doctor Ken Simon added that one of the other avenues that most may not realize is that manufactures, specialty groups, etc., may choose not to seek a national or a local coverage determination for a product, device or biologic. Instead the specialty group may come to the Outpatient Prospective Payment System (OPPS) and seek past, status or new device categorization. The coverage group never gets involved in that process. The payment side of the agency is then faced with working with local contractors to develop a code and payment for a service. Once a procedure, device or biologic has a code and a payment linked to it, it does not mean that it is a covered service. However, what often occurs, once a product has a code and linked payment, is that it ends up being covered in the absence of evidence being presented or with only scant evidence. In conclusion, there are many avenues to get a code for a product, device or biologic and get payment.

IX. Election of Rotating Seats

David H. Regan, MD, from the American Society of Hematology and American Society of Clinical Oncology was elected to serve as the Internal Medicine Rotating seat. Charles A. Mick, MD, from the North American Spine Society was elected to serve as the Other Rotating seat.

X. Relative Value Recommendations for CPT 2005

**Gastric Restrictive Procedure (Tab 5)**

**Michael Edye, MD, FACS, Society of American Gastrointestinal Endoscopic Surgeons (SAGES)**

**Christine Ren, MD, FACS, American Society of Bariatric Surgery (ASBS)**

The CPT Editorial Panel created code 43845 *Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)* to detail currently undescribed open bariatric surgical procedures.



The RUC reviewed the survey data of approximately 44 bariatric and gastrointestinal endoscopic surgeons. The RUC observed that although the specialty societies' reference service code, CPT code 43847 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption* (work RVU=26.88) has a greater total time than the new code (673 minutes versus 597 minutes) 43847 requires less pre-service time, technical skill and intra-operative intensity/complexity when compared to the new code. Therefore, the specialty societies recommended the survey median RVU of 31.00. In addition, the RUC compared CPT code 35081 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta* (work RVU=27.97) from the Multi-Specialty Points of Comparison (MPC) list to the new code, which has similar pre- and intra-service time and intra-operative intensity. **The RUC agreed with the specialty societies' recommendation and rationale and recommends a work RVU of 31.00 for code 43845.**

#### Practice Expense

The RUC assessed and approved the standard inputs for this 090-day global period code performed only in the facility setting.

### XI. Relative Value Recommendations for CPT 2006

#### Free Skin Grafts (Tab 6)

**Richard J. Kagan, MD, American Burn Association (ABA)**

**Keith Brandt, MD, American Society of Plastic Surgeons (ASPS)**

**Lloyd S. Smith, DPM, American Podiatric Medical Association (APMA)**

**Frank Spinosa, DPM, American Podiatric Medical Association (APMA)**

In response to requests from the CPT Editorial Panel to clarify the reporting of CPT codes 15400 and 15401 *Application of xenograft, skin*, specifically and the entire free skin graft section of CPT more generically, the American Burn Association developed a coding proposal encompassing 45 new and revised CPT codes. The current codes in *CPT 2005* do not describe the many new methods that have become available for the treatment and healing of extensive burn and skin wounds. These new and revised CPT codes will describe the various application techniques that are available today.

A survey was mailed to sixty burn surgeons and podiatrists. The specialty societies then developed recommendations using this survey data and physician time for presentation to the RUC. In general, the society presented the 25<sup>th</sup> percentile of the survey results for the work value and the RUC agreed that the relationships established in the survey results should be utilized to value these services. A summary of each code and the physician

time (based on the survey median) is attached to this summary. The RUC reviewed work value recommendations and direct practice expense inputs for each of the following services:

15000 (FF1) *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children*

The RUC agreed that the CPT changes were editorial in nature and recommends no change to the work relative value. This recommendation is also supported by the 25<sup>th</sup> percentile of the survey results. **The RUC recommends a work value of 3.99.**

15001 (FF2) *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)*

The RUC agreed that the CPT changes were editorial in nature and recommends no change to the work relative value. This recommendation is also supported by the 25<sup>th</sup> percentile of the survey results. **The RUC recommends a work value of 1.00.**

15040 (FF3) *Harvest of skin for tissue cultured skin autograft; 100 sq cm or less*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. This service describes the harvesting of normal skin, which is then sent to an institution to be cultured into thin epidermal autografts to later be applied to large burn areas. Previously there was no way to report this service. The RUC also agreed that the valuation appears appropriate in comparison to the work of 15000 *FF1* (work RVU = 3.99), as 15000 includes 30 minutes of intra-service time, compared to 15 minutes for 15040 *FF3*. The difference in time accounts for the smaller size of harvested skin in 15040 and fewer passes of the dermatome needed to harvest. Also, there is less need to provide hemostasis in 15040 than 15000. **The RUC recommends a work value of 2.00.**

15110 (FF4) *Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. This service was compared to 15100 *Split graft, trunk, arms, legs*;

*first 100 sq cm or less, or one percent of body area of infants and children* (work relative value = 9.04, LOS – 4 days, 4.5 office visits) in technique, hospital, and office visits. This service is considered more intense because of the increased difficulty in harvesting ultra thin (.006 of an inch) epidermal grafts and in obtaining 100 sq cm as a single sheet graft. In addition, these extremely fragile grafts require two to three dressing changes within a week of the surgery. **The RUC recommends a work value of 9.50.**

15111 (FF5) *Epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. This service is comparable to 15101 *Split graft, trunk, arms, legs; each additional 100 sq cm, or one percent of body area of infants and children* (work relative value = 1.72), with increased intensity related to the harvesting of ultra thin epidermal grafts and obtaining 100 sq cm as a single sheet graft. **The RUC recommends a work value of 1.85.**

15115 (FF6) *Epidermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. This service was compared to 15100 *Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children* (work relative value = 9.04, LOS – 4 days, 4.5 office visits) in technique, hospital, and office visits. This service is considered more intense because of the increased difficulty in harvesting ultra thin (.006 of an inch) epidermal grafts and in obtaining 100 sq cm as a single sheet graft. In addition, these extremely fragile grafts require two to three dressing changes within a week of the surgery. The RUC also agreed that this service should be more work than 15110 *FF4* due to the additional complexity needed to preserve critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 9.81.**

15116 (FF7) *Epidermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The specialty and the RUC reviewed the survey 25<sup>th</sup> percentile (work value 1.25) and felt that the increased complexity needed to preserve the critical structures of the face and other anatomic areas listed in this descriptor should lead to a higher value than 15111 *FF5* (work relative value = 1.85). Accounting for the additional intra-service time of 10 minutes and the

increased intensity of this service, the RUC estimated a work value of 2.50 for this service. **The RUC recommends a work value of 2.50.**

15130 (FF8) *Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. This service involves removing an epidermal split thickness graft off of a donor site, removing the dermal graft from underneath, and then putting the epidermal graft back down. The dermal autograft is then transferred to the recipient site. 15130 FF8 is more work than CPT 14020 *Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less* (work RVU = 6.58), as 14020 is primarily an outpatient procedure, including four typical office visits, but no hospital work as included in 15130. **The RUC recommends a work value of 7.00**

15131 (FF9) *Dermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. CPT code 15131 FF9 is less work than 15101 *Split graft, trunk, arms, legs; each additional 100 sq cm, or one percent of body area of infants and children* (work relative value = 1.72), with less intra-service time. This service is expected to be rarely reported (fewer than 100 times per year to Medicare patients). **The RUC recommends a work value of 1.50**

15135 (FF10) *Dermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey median, as the increased complexity needed to preserve the critical structures of the face and other anatomic areas listed in this descriptor should lead to a higher value than 15130 FF8 (work relative value = 7.00). This service involves removing an epidermal split thickness graft off of a donor site, removing the dermal graft from underneath, and then putting the epidermal graft back down. The dermal autograft is then transferred to the recipient site. **The RUC recommends a work value of 10.50.**

15136 (FF11) *Dermal autograft face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. Although this service is more intense than 15131 *FF9* (work value 1.50), the survey intra-service time for this service is a few minutes shorter than 15131. This is related to the limited coverage to small areas with exposed critical structures. In addition, the RUC noted that the increment in the base codes of 15130 *FF8* and 15135 *FF10* sufficiently incorporate the increased complexity of the patient. This service is expected to be rarely reported (fewer than 100 times per year to Medicare patients). **The RUC recommends a work value of 1.50.**

15150 (FF12) *Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less*

The RUC agreed with the specialties' recommendation of the survey median. This service involves tissue that has been sent off and cultured and has been retrieved to be applied. This tissue comes in 25 sq cm units. Each 25 sq cm must be applied separately. The tissue usually requires one month to culture. It was noted again that this base code incorporates all of the visits, rather than allocating any to the add-on services 15151 *FF13* or 15152 *FF14*. The RUC agreed that the intra-operative work of 15150 *FF12* is similar to 15100 (work relative value = 9.00) in that each graft must be secured to the recipient site. However, 15150 represents overall less work than 15100 as the graft is smaller (25 sq cm versus 100 sq cm) and there is no need for harvesting. **The RUC recommends a work value of 8.25.**

15151 (FF13) *Tissue cultured epidermal autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (do not report more than once)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The intra-operative work of 15151 *FF13* is similar to 15101 (work relative value = 1.72). **The RUC recommends a work value of 2.00.**

15152 (FF14) *Tissue cultured epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that 15152 *FF14* should be valued higher than 15151 *FF13* as the size of the autograft is larger (additional 1 sq cm to 75 sq cm in 15151 compared to each additional 100 sq cm in 15152). **The RUC recommends a work value of 2.50.**

15155 (FF15) *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 25 sq cm or less*

The survey data for this service did not reflect the appropriate relationship between 15155 *FF15* and 15150 *FF12* (work relative value = 8.25). The RUC agreed that the specialties' recommended value of 9.00 reflects the appropriate relationship to 15150 *FF12*, as the incremental increase is required to account for increased complexity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 9.00.**

15156 (FF16) *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (do not report more than once)*

The survey data for this service did not reflect the appropriate relationship between 15156 *FF16* and 15151 *FF13* (work relative value = 2.00). The RUC agreed that the specialties' recommended value of 2.75 reflects the appropriate relationship to 15151 *FF13*, as the incremental increase is required to account for increased complexity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 2.75.**

15157 (FF17) *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that the specialties' recommended value of 3.00 reflects the appropriate relationship to 15152 *FF14* (work relative value = 2.50) as the incremental increase is required to account for increased complexity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 3.00.**

15170 (FF18) *Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service is more work than CPT code 15350 *Application of allograft, skin; 100 sq cm or less* (work relative value = 3.99) as there is extra care necessary to secure the packaged product and to provide complete single layer coverage (without overlapping) of the recipient

site as the packaged product will become part of the permanent coverage. Three hospital visits are required to represent the work involved with dressing changes prior to the recipient areas being covered with permanent skin grafts. No office visits are required as these visits will be included in the permanent skin graft code. **The RUC recommends a work value of 5.00.**

15171 (FF19) *Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that 15171 *FF19* reflects more work than 15351 *Application of allograft, skin; each additional 100 sq cm* (work relative value = 1.00) as there is extra care necessary to secure the packaged product and to provide complete single layer coverage (without overlapping of the recipient site as the packaged product will become part of the permanent coverage). **The RUC recommends a work value of 1.55.**

15175 (FF20) *Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed that this service involves more work than CPT code 15350 *Application of allograft, skin; 100 sq cm or less* (work relative value = 3.99) as extra care is necessary to secure the packaged product and to provide complete single layer coverage (without overlapping) of the recipient site as the packaged product will become part of the permanent coverage. Three hospital visits are required to represent the work involved with dressing changes prior to the recipient areas being covered with permanent skin grafts. No office visits are required as these visits will be included in the permanent skin graft code. The RUC agreed with the specialty society's determination that an increment of work above 15170 *FF18* (work relative value = 5.00) to reflect the increased intensity of preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 7.00.**

15176 (FF21) *Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that 15176 *FF21* reflects more work than 15351 *Application of allograft, skin; each additional 100 sq cm* (work relative value = 1.00) as extra care is necessary to secure the packaged product and to

provide complete single layer coverage (without overlapping of the recipient site as the packaged product will become part of the permanent coverage. In addition, the RUC agreed that the increment of work above 15171 *FF19* is appropriate to reflect the increased intensity of preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 2.45.**

15300 (FF22) *Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. CPT code 15300 *FF22* describes the same work as the existing code 15350 *Application of allograft, skin; 100 sq cm or less* (work relative value = 3.99). **The RUC recommends a work value of 3.99.**

15301 (FF23) *Allograft skin for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. CPT code 15301 *FF23* describes the same work as the existing code 15351 *Application of allograft, skin; each additional 100 sq cm* (work relative value = 1.00). **The RUC recommends a work value of 1.00.**

15320 (FF24) *Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that the additional increment of work above 15300 *FF22* was appropriate to reflect the increased intensity in preserving critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 4.70.**

15321 (FF25) *Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that the additional increment of work above 15301 *FF23* was appropriate to reflect the increased intensity in preserving critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 1.50.**



15330 (FF26) *Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. This service describes application of a prepared product that cannot stand alone and is placed under a flap or graft. Therefore, this service is always reported on the same date as another service with a -51 modifier. CPT code 15330 *FF26* describes the same work as the existing code 15350 *Application of allograft, skin; 100 sq cm or less* and 15300 *FF22* (work relative value = 3.99). **The RUC recommends a work value of 3.99.**

15331 (FF27) *Acellular dermal allograft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. CPT code 15331 *FF27* describes the same work as the existing code 15351 *Application of allograft, skin; each additional 100 sq cm* and 15301 *FF23* (work relative value = 1.00). **The RUC recommends a work value of 1.00.**

15335 (FF28) *Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The specialty society presented and the RUC agreed that the value should incorporate an appropriate increment of work for the increased intensity of preserving critical structures of the face and other anatomic areas listed in this descriptor and, therefore, recommended 4.50, a slight increase above 15330 *FF26* (work relative value = 3.99). This service describes application of a prepared product that cannot stand alone and is placed under a flap or graft. Therefore, this service is always reported on the same date as another service with a -51 modifier. This service is slightly less work than 15320 *FF24* the hospital work is included in other services. **The RUC recommends a work value of 4.50.**

15336 (FF29) *Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this represents an appropriate increment of work above 15331 *FF27* (work relative value = 1.00) to reflect the increased

intensity of preserving the critical structures of the face and other anatomic areas listed in this descriptor. This service is slightly less work than 15321 *FF25* the hospital work is included in other services. **The RUC recommends a work value of 1.43.**

15340 (FF30) *Tissue cultured allogeneic skin substitute; first 25 sq cm or less*

The typical patient for this service is a Type II Diabetic with a non-infected full thickness ulceration of the heel. The intra-work of this service includes: local anesthesia, debridement, achieve adequate hemostasis, measuring the wound, obtaining graft material, applying the material, and suturing. The survey results were not utilized for this service as at the time of the survey, CPT had not yet indicated that debridement was included in this service. CPT has since clarified that debridement (currently reported with CPT codes 15000, 11040 – 11042) is no longer separately reported. The specialty presented a recommendation based on the following building block:

Pre-Service Evaluation and Positioning	15 minutes x .0224 =	0.34
Pre-Service Scrub, Dress, and Wait	10 minutes x .0081 =	0.08
Intra-Service Work (20 min survey + 8 minutes of debridement)	28 minutes x .0520 =	1.46
Immediate Post-Service Time	15 minutes x .0224 =	0.34
½ day discharge day 99238		0.64
Two, 99212 office visits (10 day global)		<u>0.86</u>
Calculated Work Relative Value		<b>3.72</b>

**The RUC recommends a work value of 3.72.**

15341 (FF31) *Tissue cultured allogeneic skin substitute; each additional 25 sq cm*

The RUC agreed with the specialties' recommendation of the survey median. This service also includes any additional debridement required. It was noted that the IWP/UT (0.033) represented in this recommendation approximates the current IWP/UT for E/M services. **The RUC recommends a work value of 0.50.**

15360 (FF32) *Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC considered this to be slightly less work than 15350 and 15300 *FF22* (work relative values = 3.99). However, it was noted that office visits should be assigned to this code as this service is considered as the final

management of the wound and extra care in application is necessary. **The RUC recommends a work value of 3.87.**

15361 (FF33) *Tissue cultured allogeneic dermal substitute, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. This represents slightly more work than 15351 and 15301 FF23 as this coverage is considered as the final management of the wound and extra care in application is necessary. **The RUC recommends a work value of 1.15.**

15365 (FF34) *Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that a work value of 4.15 represented the appropriate increment of increased work above 15360 FF32 to justify the increased complexity in preserving the critical structure of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 4.15**

15366 (FF35) *Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that a work value of 1.45 represented the appropriate increment of increased work above 15361 FF33 to justify the increased complexity in preserving the critical structure of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 1.45.**

15400 (FF36) *Xenograft, skin (dermal) for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service should be valued the same as existing code 15400 *Application of xenograft, skin; 100 sq cm or less (work relative value = 3.99)*. **The RUC recommends a work value of 3.99.**

15401 (FF37) Xenograft; skin (dermal) for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service should be valued the same as existing code 15401 *Application of xenograft, skin; each additional 100 sq cm (work relative value = 1.00)*. **The RUC recommends a work value of 1.00.**

15420 (FF38) *Xenograft skin (dermal) for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service should be valued more than existing code 15400 *Application of xenograft, skin; 100 sq cm or less (work relative value = 3.99)* and new code 15400 *FF36* to account for the increased intensity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 4.50.**

15421 (FF39) *Xenograft skin (dermal) for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agreed that this service should be more than the existing code 15401 *Application of xenograft, skin; each additional 100 sq cm (work relative value = 1.00)* to account for the increased intensity in preserving the critical structures of the face and other anatomic areas listed in this descriptor. **The RUC recommends a work value of 1.50.**

15430 (FF40) *Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children*

The intra-work of this service includes: debridement, achieve adequate hemostasis, measuring the wound, obtaining graft material, and application of the material. The survey results were not utilized for this service as at the time of the survey, CPT had not yet indicated that debridement was included in this service. CPT has since clarified that debridement (15000, 11040 – 11042) is no longer separately reported. In addition, the RUC understands that the patient is seen back in the office each 10 days during the ninety day global period for reapplication of the acellular xenograft implant, to include any

required debridement. The specialty presented a recommendation based on the following building block:

Pre-Service Evaluation and Positioning	15 minutes x .0224 =	0.34
Pre-Service Scrub, Dress, and Wait	10 minutes x .0081 =	0.08
Intra-Service Work	15 minutes x .0400 =	0.60
Immediate Post-Service Time	10 minutes x .0224 =	0.22
½ day discharge day 99238		0.64
Nine, 99212 office visits (1 each 10 days of 90 day global)		<u>3.87</u>
Calculated Work Relative Value		5.75

**The RUC recommends a work value of 5.75.**

15431 (FF41) *Acellular xenograft implant; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*

The presenting specialty societies indicated that their members do not use this product for large burns/wounds. However, the presenters noted that this service may be provided by some trauma surgeons. **The RUC recommend that this service be carrier priced in 2006.**

16020 (FF42) *Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agrees that the CPT revisions clarified the current reporting of these services. **The RUC recommends a work value of 0.80.**

16025 (FF43) *Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (e.g., whole face or whole extremity, or 5 to 10% total body surface area)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agrees that the CPT revisions clarified the current reporting of these services. **The RUC recommends a work value of 1.85.**

16030 (FF44) *Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (e.g., more than one extremity, or greater than 10% total body surface area)*

The RUC agreed with the specialties' recommendation of the survey 25<sup>th</sup> percentile. The RUC agrees that the CPT revisions clarified the current reporting of these services. **The RUC recommends a work value of 2.08.**

### Work Neutrality

The RUC acknowledges that the relative value recommendations for these services are not work neutral. Based on the best estimates on projected utilization, the overall increase in work values for the entire family of services is 6%. The RUC recommends that any minor adjustment that would be necessary be made to the overall budget neutrality adjustment to the conversion factor, rather than to these codes. The RUC agreed that compelling evidence was presented by the specialties that the new codes do describe new technology for burns and chronic wounds. In addition, the current valuation of codes 15342 and 15343 *Application of bilaminar skin substitute/neodermis* is not based on any survey data or input from the specialties providing this service. These product applications have never been clearly defined. The new codes and the corresponding valuation incorporates the major differences in the application of the skin substitutes, include: application techniques; patient population; site-of-service; physician time; and length of stay.

### Global Period Assignment

The RUC evaluated each of these services based on the historical global periods for this family and the global periods assigned by CMS for the new/revised CPT codes. However, the RUC is concerned that the assignment of a 090 day global period for these codes and other codes typically reported for patients with burns and chronic wounds may be problematic and we urge CMS to consider this issue. The typical patient would receive services over the course of several weeks and months that would each be assigned 90 day global periods. The RUC is concerned that the current reporting mechanism leads to a duplication in the number of post-operative visits included in these codes, as there is no reduction in payment for staged procedures (CPT modifier -58). In addition, a burn patient may have wounds on many anatomical areas, sometimes treated over different days. Again, a duplication in payment for post-service care would occur under the current coding system. The RUC would be interested in re-reviewing these services, if the specialty and CMS conclude that a change in global period assignment is warranted. The RUC would also note that analyses such as IWPUT are not effective for these codes, as the number of visits for the typical patient is included in the base code, even though the add-on code describes the larger burns/wounds. The RUC did not assign any pre or post service work to the add-on (ZZZ) codes. However, the work in these codes reflects the increased intensity of the larger burn/wound.

### Practice Expense

The RUC made several modifications to the direct practice expense recommendations to reflect a relationship of 2/3 nurse time to physician time for assisting the physician when the service is performed in the non-facility. In addition, the direct practice expense inputs were modified to reflect consistency with the physician time data post-operative office visits. Minor

revisions were also made to the medical supplies and equipment, including a clarification that the skin substitute/grafts should be reported separately, as described in the CPT preamble to these codes: “*When services are performed in office, the supply of the skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately.*” The direct practice expense recommendations are attached to this recommendation.

**Apical Lung Tumor Resection and Chest Wall Resections (Tab 7)**  
**Keith Naunheim, MD, Society of Thoracic Surgeons (STS)**

CPT deleted three codes pertaining to lung resections because it was determined that the descriptors were ambiguous. CPT then created two new lung resection codes that more accurately describe the variation in the amount of lung resected and the work involved in these procedures. The RUC agreed with the presenters’ rationale for not applying work neutrality. According to the presenters, the deleted codes are not specific regarding the variation in the amount of lung resected (eg, wedge resection versus pneumonectomy), which can represent substantial differences in work for the surgeon. Additionally, the RVUs of these codes are based on the original Harvard study valuations with no documentation regarding what type of resections were included in the initial MFS valuation.

The presenters also made a case that this family of codes represented a significant rank order anomaly with the individual resection and reconstruction code families (eg, 32520 Resection of lung *and* chest wall has an RVW of 21.65 and 32500 Wedge resection has an RVW of 21.97). The presenters contend that the lung resection with chest wall resection codes represent a rank order anomaly within the lung procedures as the current work values do not even account for the basic work of a wedge resection, which would be the minimal amount of lung resection that may be involved in this procedure. The RUC agreed with this compelling evidence to not apply work neutrality to these codes.

32503 and 32504

The RUC reviewed code 32503 *Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)* and code 32504 *Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction(s)* together to determine proper rank order. For code 32503 the RUC agreed that the median survey value of 30.00 RVUs placed the code in proper rank order and accurately reflected the physician work of this code. Once this value was determined the RUC evaluated the incremental work involved in chest wall reconstruction. The RUC agreed with the presenters that the survey respondents underestimated the

incremental work involved in reconstruction by in effect only adding one RVU for an additional hour of work.

The RUC agreed with the following methodology to value 32504. The surveyed difference in total work between the 32503 and 352X2 is 60 minutes additional intraoperative time for chest wall reconstruction. Using the IWPUR of 0.080 for 32503, an RVW of 34.80 is calculated for code 32504. This RVW provides an additional 4.80 RVUs for the one hour of additional work for chest wall reconstruction. The IWPUR of 0.080 is the same as the IWPUR for 352X1, appropriately similar to the IWPUR for 32480, *Removal of lung, other than total pneumonectomy; single lobe (lobectomy)* (work RVU=23.71, IWPUR =0.084) and less than the IWPUR for MPC reference codes 33405 *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve* (work RVU =34.95, IWPUR = 0.099) and 35646 *Bypass graft, with other than vein; aortobifemoral* (work RVU =30.95, IWPUR = 0.092).

**The RUC recommends a work RVU of 30.00 for code 32503**

**The RUC recommends a work RVU of 34.80 for code 32504**

#### Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed in the facility setting with the exception of using the RN staff type rather than the standard staff blend.

#### **Incision and Drainage Spinal Deep Abscess (Tab 8)**

**Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS)**

**Charles Mick, MD, North American Spine Society (NASS)**

The CPT Editorial Panel created two new codes to describe incision and drainage of deep spinal abscesses, which were inadvertently deleted when spine codes were revised.

The RUC reviewed the survey data for 22010 *Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic* and 22015 *Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral* and determined that codes 22010 and 22015 involved more pre-, intra- and post- service time, as well as a higher intensity of mental effort, technical skill and psychological stress than the reference code 26990 *Incision and drainage, pelvis or hip joint area; deep abscess or hematoma* (work RVU=7.47). However, the RUC observed that the median survey data on the pre-service evaluation time appeared high. The RUC reduced the pre-service evaluation time for 22010 and 22015 from 45 minutes to 30 minutes. **The RUC recommends a work RVU of 11.05 for 22010 and 10.94 for 22015.**



Code	Pre-Service Eval	Pre-Service Positioning	Pre-Service Scrub, Dress, Wait	Intra-Service	Post-Service	Work RVU
22010	30	20	15	60	30	11.05
22015	30	15	15	60	30	10.94

#### Practice Expense

The RUC assessed and approved the standard 090-day global facility only practice expense inputs for 22010 and 22015.

#### **Vertebral Augmentation - Kyphoplasty (Tab 9)**

**Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS)**

**Charles Mick, MD, North American Spine Society (NASS)**

*Facilitation Committee #2*

The CPT Editorial Panel created three new codes to accurately report distinct, multi-step, open or percutaneous, fluoroscopic guided, fracture reduction, cavity creation, vertebral augmentation/stabilization surgical procedures which treat progressive osteopathic and osteolytic vertebral compression fractures.

#### 22523

The RUC discussed 22523 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic*. After reviewing the survey data, the RUC felt that a reduction in the specialty societies' recommended pre-service time: 53 minutes evaluation time, 18 minutes positioning time, and 15 minutes scrub, dress and wait time was necessary to accurately reflect the physician pre-service time. The specialty societies responded by proposing reduced pre-service times: 30 minutes evaluation time, 15 minutes positioning time, and 15 minutes scrub, dress and wait time. They also stated that although they were comfortable modifying the pre-service times, they would like to maintain their original specialty societies' recommendation of 8.94 RVUs. The specialty societies reiterated that the value of 8.94 RVUs reflected their consensus panel's recommendation to remove the work associated with the 99232 hospital visit from the 25<sup>th</sup> percentile of their survey results. The specialty societies felt this value is appropriate as compared to the reference service code, 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic* (Work RVU=8.89) as the surveyed code and the reference code had similar total service times (197 minutes and 199 minutes, respectively) and the surveyed code was deemed slightly more intense and required greater technical skill and effort than the reference code.

**The RUC agreed with the specialty societies' amended pre-service times and work RVU and recommends 8.94 RVUs for 22523.**

22524

The RUC discussed 22524 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar*. The RUC reviewed the specialty societies' survey data. The survey data demonstrates that the reference code 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar* (Work RVU=8.33) has lower intensity/complexity measures when compared to the surveyed code. In addition, the specialty society recommended that the approved pre-service times of 22524 be revised to mirror the recommended pre-service times of 22523 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic* (30 minutes evaluation time, 15 minutes positioning time, and 15 minutes scrub, dress and wait time). However, because the specialty society felt that the median and 25<sup>th</sup> percentile RVW survey results were not accurate, the specialty societies recommended using an IWPUT analysis to derive the work associated with this procedure. The specialty societies recommended a value of 8.54 RVUs for 22524 as this RVU recommendation is based on an IWPUT intensity value that is slightly lower than 22523 (0.094 and 0.092, respectively) and therefore preserves the rank-order structure between 22523 and 22524. The RUC agreed with the specialty societies' recommendation. **The RUC recommends the specialty societies' amended pre-service times and work value of 8.54 work RVUs for 22524.**

22525

The RUC discussed 22525 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body*. The specialty societies explained their recommendation by stating that the 10 minutes of pre-service time and the 5 minutes of immediate post-service time has been deleted (as well as the associated work RVUs from the 25<sup>th</sup> percentile of their survey results) as this is an add-on code and it was felt by the specialty societies' consensus panel that the inclusion of this time was survey respondent error. Also, the specialty societies recommended value of 4.47 work RVUs for the surveyed code when compared with the reference service code 22522 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body* (Work RVU=4.30) is appropriately placed as the surveyed and reference code have similar times (40 and 50 minutes respectively) and that the surveyed code was deemed more intense and required greater technical skill

and effort than the reference code. **The RUC agreed with the specialty societies' amended pre-/post-service times and work RVU and recommends 4.47 work RVUs.**

The RUC noted that the reference codes, selected as a comparison to value these new procedures, have been identified to be reviewed in the Five Year Review process. Therefore, the RUC may need to re-evaluate the work associated with these new procedures if the work associated with the percutaneous vertebroplasty codes changes.

Practice Expense:

The RUC approved the practice expense inputs as recommended by the specialty societies with one modification. When 22523 and 22524 are performed in the facility setting, the discharge day management service 99238 should be reduced from 12 minutes to 6 minutes to reflect that 99238 is performed on the same day. **The RUC approved this reduction in the practice expense inputs.**

**Coronary Artery Anomaly Unroofing (Tab 10)**

**Kirk Kanter, MD, Society of Thoracic Surgeons (STS)**

CPT created a new code for the repair of anomalous aortic origin of coronary artery due to the availability of new echocardiography imaging technology that allows the detection of a coronary artery anomaly. There was not a current CPT code that described the repair of the anomaly.

The presenters stated that this is a risky procedure because of the risk of injuring the aortic valve or the coronary artery during the procedure. Based on a comparison with the reference code, the RUC agreed that the median survey value of 30.00 RVUs was appropriate. The presenters noted that although there were only 22 respondents to the survey this represented about 10% of the surgeons that performed this procedure. The RUC noted that the times listed for the reference codes were Harvard data rather than more recent RUC data and were concerned that the lower Harvard times may have skewed the final specialty society recommendation. The presenters stated that the value of reference service 33504 *Repair of anomalous coronary artery; by graft, with cardiopulmonary bypass* (work RVU=24.62) was based on RUC data from 1993 but also stated that the reference code is significantly undervalued and that the RUC data from the early days of the RUC may not have been completely accurate. This code was presented as part of a much larger presentation of 80 cardiothoracic codes in 1993 and the data presented for this code may have been undervalued. Also, only 1/3<sup>rd</sup> of the survey respondents choose this code as the reference service and since the respondents were not provided the times, the recommended RVU survey results should be valid. Both procedures are low volume codes where it is difficult to obtain accurate data. The RUC was

convinced that the 240 minutes intra-service time for reference code 33504 may be an error. The RUC also compared 33507 to MPC codes such as 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU= 33.95, intra-service time =225) and code 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (work =36.15, intraservice time = 240 minutes) and felt that the recommended median value of 30.00 RVUs and intra-service time of 180 minutes was appropriate especially in light of an IWPUT of 0.101. Based on the description of the procedure and the intensity involved including the work of a post-operative ICU visit, the RUC was convinced that the recommended value of 30.00 is appropriate.

**The RUC recommends a work RVU of 30.00 for code 33507.**

Additionally, because the RUC felt that reference code 33504 may be undervalued, the RUC passed the following motion: **The RUC supports the specialty society's efforts to survey the reference service code 33504 and present the results to the RUC for consideration, provided CMS supports evaluation of the code.**

#### Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed in the facility setting with the exception of using the RN staff type rather than the standard staff blend.

#### **Ventricular Restoration (Tab 11)**

**John Conte, MD, Society of Thoracic Surgeons (STS)**

Due to advancements in technology that has allowed for standardization of the restoration of the ventricle, CPT created a new code to account for this type of procedure that is technically more complicated and involves different work than is described by current codes.

The presenters stated that the existing code 33542 *Myocardial resection (eg, ventricular aneurysmectomy)* (work RVU = 28.21) involves different work and does not accurately describe this procedure. The presenters stated that patients undergoing ventricular restoration are among the sickest patients with advanced heart failure with the average patient staying in the ICU post-operatively 4-5 days. The RUC agreed that the median survey value of 37.97 work RVUs was appropriate especially given an intra-service time of four hours. The presenters clarified that in about 80 to 90 percent of these patients, bypass surgery is also performed at the same time and it was explained that the recommended value does not include any of the bypass surgery work. However, there was considerable discussion regarding the specialty request to include this new code in the upcoming five-year review. The presenters felt that because the reference services used to value this code are included in the

five-year review and may have underestimated intra-service time, those responding to the survey may have undervalued the new code by using an undervalued reference service. The presenters cited as evidence an IWPUT of 0.082 for this new code as being too low. The RUC agreed that an interim value could be assigned and the presenters would present new data based on the STS five-year review alternative methodology for RUC consideration in September, 2005.

**The RUC recommends an interim work RVU of 37.97 for code 33548.**

Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed in the facility setting with the exception of using the RN staff type rather than the standard blend.

**Cavopulmonary Shunting (Tab 12)**

**Kirk Kanter, MD, Society of Thoracic Surgeons (STS)**

CPT created a new add-on code to report the additional work of performing an additional cavopulmonary anastomosis for bilateral superior venae cavae since the current codes do not capture this work that occurs in about 10% of cases.

The presenters stated that the survey respondents significantly underestimated the time of this code and therefore resulting in an overstated IWPUT. The presenters explained that the significant amount of work involved can not be done in only 30 minutes, which was the median survey intra-service time. The RUC agreed that this time was not accurate and concluded that the RUC recommendation should state that the median time value is an underestimate; therefore the resulting IWPUT should not be used. The RUC agreed that given the intensity of this procedure it was valued correctly, especially in comparison with the other congenital add-on code 33294 *Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure* (Work RVU = 5.94, intra-service time = 30 minutes). Although the RUC did not agree on an appropriate intra-service time, the RUC felt that it is greater than 30 minutes and the value should be higher than 33294. The RUC agreed that the median recommended RVU of 8.00 was appropriate and would place the code in proper rank order especially in relation to 33294.

**The RUC recommends a work RVU of 8.00 for code 33768.**

Practice Expense

The RUC recommends zero practice expense inputs for code 3376X as it is an add-on code performed only in the facility setting.

**Repair of Pulmonary Artery Arborization Anomaly (Tab 13)**

**Kirk Kanter, MD, Society of Thoracic Surgeons (STS)**

CPT created two new codes and deleted two existing codes because the current codes do not adequately describe the procedure that is typically performed. The presenters stated that in most cases, the children undergoing this procedure have arborization abnormalities of the branch pulmonary arteries that need to be brought to a more central confluence (unifocalization) prior to complete repair of the heart defects. Usually, this unifocalization is performed as a staged procedure (first one side, then the other, if necessary) through a thoracotomy incision without the use of cardiopulmonary bypass. A systemic-to-pulmonary artery shunt may be constructed at the same time. Thus, it is uncommon for the actual cardiac portion of the defect (pulmonary atresia with ventricular septal defect) to be dealt with at this operation as is described in the current codes.

The RUC noted that the specialty society provided Harvard time data rather than RUC data for the reference code 33503 *Repair of anomalous coronary artery; by graft, without cardiopulmonary bypass* (work RVU = 21.75, intra-service time 240 minutes), therefore the IWPUT calculations for the reference service is invalid. In spite of using the incorrect reference service time data, the RUC felt that the 25<sup>th</sup> percentile value of 29.50 adequately represented the physician work involved in code 33925. The code was compared to MPC codes 35631 *Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal* (work RVU = 33.95, intra-service time = 225 minutes) and code 35531 *Bypass graft, with vein; aortoceliac or aortomesenteric* (work RVU = 36.15, intra-service time = 240 minutes)

For code 33926 *Repair of pulmonary, artery arborization anomalies by unifocalization; with cardiopulmonary bypass* the RUC concluded that the median survey value of 42.00 RVUs appropriately valued the additional work involved in performing the procedure with cardiopulmonary bypass, which takes an additional hour.

**The RUC recommends 29.50 work RVUs for code 33925.**

**The RUC recommends 42.00 work RVUs for code 33926.**

**Practice Expense**

The RUC recommends the standard inputs for 90 day global procedures performed in the facility setting with the exception of using the RN staff type rather than the standard staff blend.

**Descending Thoracic Aorta Endovascular Repair (Tab 14)**

**Gary Seabrook, MD, Society for Vascular Surgery (SVS)**

**Bibb Allen, MD, American College of Radiology (ACR)**

**Robert Vogelzang, MD, Society of Interventional Radiology (SIR)**

The CPT Editorial Panel created a family of seven new codes to define new techniques for repairing aneurysm involving descending thoracic aorta endovascular repair, and four other codes associated with the placement of proximal extension prosthesis and coverage of the left subclavian artery origin. In addition, the Panel revised two open artery exposure abdominal aortic aneurysm codes, a bypass graft code, and an arterial transposition code. These changes to CPT were made to provide more specificity with the existing codes while introducing new category I codes reflecting existing practice patterns of codes that were previously category III codes. The Panel also believed that there was an urgency to move these new technology codes to category I, as minimally invasive repair of the thoracic aorta provides an alternative to the complexity and sometimes mortality of the similar open surgical procedures.

The RUC carefully reviewed the survey results of all eleven new codes associated with descending thoracic aorta endovascular repair, and agreed that the specialty society's recommended physician work values were correctly rank ordered and well justified. The RUC first addressed the surgical aspects of endovascular repair and then the diagnostic radiology aspects.

**33880**

The RUC reviewed the specialty society recommended median survey results for code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin*, and understood the significant work involved for this service. The RUC reviewed this code against its RUC reviewed reference code 34803 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)* (090 day global, Work RVU = 24.00), and determined this new code involved more time and intensity. The RUC agreed with the intensity and physician time in the pre-intra and immediate post periods, for this new code, however did not agree with the level four office visit shown in the specialties' survey results. The RUC recommended, and the specialty agreed, that the level four office visit should be changed to a level three. **The RUC recommends the modification to the specialties' surveyed results to indicate two level three post operative visits rather than one level three and one level four. The RUC also recommends a relative work value of 33.00 for code 33880.**

33881

The RUC reviewed the specialty society recommended median survey results for code 33881 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin*, and understood its rank order in relation to 33880. The RUC reviewed this code against its RUC reviewed reference code 34803 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)* (090 day global, Work RVU = 24.00), and determined this new code involved more time and intensity. The RUC agreed with the intensity and physician time in the pre-intra and immediate post periods, for this new code, however did not agree with the level four office visit shown in the specialties' survey results. The RUC recommended, and the specialty agreed, that the level four office visit should be changed to a level three. **The RUC recommends the modification to the specialties' surveyed results to indicate two level three post operative visits rather than one level three and one level four. The RUC also recommends a relative work value of 28.00 for code 33881.**

33883

The RUC reviewed the specialty society recommended median survey results for code 33883 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); initial extension*, and understood that it is a complex and challenging endovascular procedure. The RUC examined the specialties' RUC surveyed key reference code 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel*, (090 global, Work RVU = 11.98), and believed the survey results that indicated higher levels of physician time and complexity. The RUC agreed with the intensity and physician time in the pre-intra and immediate post periods, for this new code, however did not agree with the level four office visit shown in the specialties' survey results. The RUC recommended, and the specialty agreed, that the level four office visit should be changed to a level three. **The RUC recommends the modification to the specialties' surveyed results to indicate two level three post operative visits rather than one level three and one level four. The RUC also recommends a relative work value of 20.00 for code 33883.**



33884

The RUC reviewed the specialty society recommended 75<sup>th</sup> percentile survey results for code 33884 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); each additional proximal extension* and believed that intensity is comparable to its key reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure) (ZZZ day global, Work RVU = 4.12)*. The specialties' survey results indicated a median survey work value of 7.00, however the RUC agreed with the specialty that placing an additional proximal thoracic endovascular extension is justifiably 20% more intense than a proximal or distal additional extension in the infrarenal aorta. Therefore, considering the additional physician time and increased intensity of the service than its key reference service, the RUC agreed with the specialties' 75<sup>th</sup> percentile survey results for physician work. **The RUC recommends a relative work value of 8.20 for code 33884.**

33886

The RUC reviewed the specialty society recommended median survey results for code 33886 *Placement of distal extension prosthesis(es) delayed after endovascular repair of descending thoracic aorta* and agreed that the time and complexity was greater than its key reference 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel, (090 global, Work RVU = 11.98)*. The RUC agreed with the survey results, however disagreed with the level four office visit and recommended a reduction to a level three. The specialty agreed with the physician time change and considered it more typical. **The RUC recommends a relative work value of 17.00 for code 33886.**

33889

The RUC reviewed the specialty society survey results for code 33889 *Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral* and agreed with the specialty that the code was overvalued by the respondents which indicated a median survey value of 18.00 work RVUs for this new 000 day global service. The RUC agreed with the specialty society recommendation involving the direct comparison of code 35694 *Transposition and/or reimplantation; subclavian to carotid artery (090 day global, Work RVU = 19.13)* to this new code. The RUC agreed with the intensity comparison of the two codes and developed a building block approach, backing out the post-operative visits and applying the specialty surveyed time. **The RUC recommends a work relative value of 15.92 for code 33889.** The RUC

and specialty society also agreed that since the new code is a 000 day global code, that the post-operative time period would only encompass the immediate post service time. Therefore, the RUC recommended the specialties' surveyed discharge day management time be moved to the immediate post service time. **The RUC recommends the discharge day management time from the specialty surveyed results be moved to the immediate post service time.**

33891

The RUC reviewed the specialty society survey results for code 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* and realized that this procedure has a high level of intensity. The RUC evaluated this service and believed the median survey value of 20.00 was justified, based on the time and intensity of the new procedure. **The RUC recommends a work relative value of 20.00 for code 33891.** The RUC and specialty society also agreed that since the new code is a XXX global code, that the post-operative time period would only encompass the immediate post service time. Therefore, the RUC recommended the specialties' surveyed discharge day management time be moved to the immediate post service time. **The RUC recommends the discharge day management time from the specialty surveyed results be moved to the immediate post service time.**

The RUC was aware that all of the new imaging codes include supervision and interpretation (S&I). It was explained that the codes will be reported together with the primary codes and they are not subject to multiple procedure reduction. However, typically there would be one S&I billed, and occasionally there would be more than one.

**New Diagnostic Radiology Codes involved in Endovascular Repair**

The RUC reviewed and agreed the recommended median survey results of all the diagnostic radiology codes. The RUC was aware that all of these new imaging codes included supervision and interpretation (S&I), and that the codes would be reported together with the primary codes and would not be subject to the multiple procedure reduction. However, the specialty understood that typically there would be one S&I billed and occasionally there would be more than one.

75956

The RUC reviewed the median survey results for code 75956 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* and agreed with the specialty survey results. The RUC compared the new code to the specialties' key reference code 75952 *Endovascular repair of*

*infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (Work RVU = 4.49). The RUC understood that the new procedure involved much more time than 75952 at a similar complexity level. The time and intensity difference was understandable considering the time for the new code is based on the anatomic complexity of the aortic arch in a three-dimensional space. The RUC agreed with the specialty society survey results and recommendation. **The RUC recommends a work relative value of 7.00 for code 75956.**

75957

The RUC reviewed the median survey results for code 75957 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation* and agreed with the specialty survey results. The RUC compared the new code to the specialties' key reference code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (Work RVU = 4.49). The RUC understood that the new procedure involved much more time than 75952 at a similar complexity level. The time and intensity difference was understandable considering the time for the new code is based on the anatomic complexity of the aortic arch in a three-dimensional space. The RUC agreed with the specialty society survey results and recommendation. **The RUC recommends a work relative value of 6.00 for code 75957.**

75958

The RUC reviewed the median survey results for code 75958 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); radiological supervision and interpretation* and agreed with the specialty survey results. The RUC compared the new code to the specialties' key reference code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (Work RVU = 4.49). The RUC understood that in the intra-service period, the new procedure involved similar time as 75952 at a higher intensity. The intensity was understood whereas the proximal extension is deployed adjacent to, or crosses, the left subclavian origin. The RUC agreed with the specialty society survey results and recommendation. **The RUC recommends a work relative value of 4.00 for code 75958.**

75959

The RUC reviewed the median survey results for code 75959 *Placement of distal extension prosthesis(es) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin; radiological supervision and interpretation* and agreed with the specialty survey results. The RUC compared the new code to the specialties' key reference code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* (Work RVU = 4.49). The RUC understood that the new procedure involved less time than 75952 with a higher intensity level during the intra-service period. The RUC agreed with the specialty society survey results and its comparison to the reference code to substantiate their recommendation. **The RUC recommends a work relative value of 3.50 for code 75959.**

Practice Expense

The RUC agreed with the standard inputs for this set of codes, however the RUC made two changes in order to reflect the RUC's changes to the surveyed time and the elimination of all inputs for codes 33889-7. The post-operative visit time, supplies, and equipment were changed to reflect the reduction in one post operative visit for codes 33880-3, and 33886. In addition, the practice expense of codes 33889-7 were eliminated as they are billed with the other major procedures within the family at the same time.

**Mechanical Thrombectomy (Tab 15)**

**Gary Seabrook, MD, Society for Vascular Surgery (SVS)**

**Bibb Allen, MD, American College of Radiology (ACR)**

**Robert Vogelzang, MD, Society of Interventional Radiology (SIR)**

The CPT Editorial Panel created four new codes because current CPT codes describe procedures that alter the anatomy of the artery by modification of the arterial wall or removal of a portion of a plaque and not the removal of thrombus within the lumen of a vessel. The new codes describe a group of related procedures that use unique percutaneous methods of fragmenting/macerating and/or removal of clots. Therefore, the creation of these codes will help ensure patient access to all methods of thrombus removal, allowing the optimal method to be chosen for each patient.

The RUC reviewed the specialty societies' recommendations for the four new mechanical thrombectomy codes for work and practice expense. Each of the new codes were evaluated against its key reference service and other comparable codes across specialties. The RUC discussed each code recommendation with the specialty society and assisted in revising the specialty recommendation prior to the full RUC meeting to reflect the typical patient encounter. These revisions included a reduction in the pre-service time and a reduction in the work relative value recommendations. The RUC further agreed

with the specialty who believed the work intensity for the family of codes was similar to the intensity of RUC reviewed add-on code 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)* (Work RVU= 3.28) of 0.082. The details of each of these RUC recommendations are shown below.

**37184**

The RUC reviewed code 37184 *Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). The RUC also compared the code to RUC surveyed, MPC list code 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)* (090 day global, Work RVU = 11.27), and backed out all post operative time to reflect a 000 day global procedure. The RUC believed that the value of the new code is less intense than 58660, and believed the intensity of this new code is comparable to code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28). The RUC applied a building block approach using the intensity of 92973 after reducing the physician time in the pre-service to a total of 40 minutes from 60 minutes to reflect the typical patient encounter. **The RUC recommends a work relative value of 8.66 for code 37184.**

**37185**

The RUC reviewed add-on code 37185 *Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). The RUC also compared the 37185 to RUC surveyed code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28), as it utilizes the same technology. The RUC applied a building block approach using the intensity of 92973. **The RUC recommends a work relative value of 3.28 for code 37185.**

**37186**

The RUC reviewed add-on code 37186 *Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); secondary percutaneous transluminal thrombectomy (eg, non-primary mechanical, snare basket, suction technique)*

*non-coronary, arterial or arterial bypass graft including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). The RUC also compared the 37186 to RUC surveyed code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28), and to 37184. The RUC applied a building block approach using the intensity of 92973 and 37184 and 60 minutes from the specialty survey. **The RUC recommends a work relative value of 4.92 for code 37186.**

### **37187**

The RUC reviewed code 37187 *Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). It was understood by the RUC that code 37187 involved more intra-service time than its reference code and that it is more complex and intense. The RUC also compared the code to RUC surveyed, MPC list code 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)* (090 day global, Work RVU = 11.27), and backed out all post operative time to reflect a 000 day global procedure. The RUC believed that the value of the new code is less intense than 58660, and believed the intensity of this new code is comparable to code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28). The RUC applied a building block approach using the intensity of 92973 after reducing the physician time in the pre-service to a total of 40 minutes from 73 minutes to reflect the typical patient encounter. **The RUC recommends a work relative value of 8.03 for code 37187.**

### **37188**

The RUC reviewed code 37188 *Percutaneous transluminal mechanical thrombectomy, non-coronary, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy* for its physician time and intensity against its key reference service, RUC surveyed 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* (090 day global, Work RVU = 5.15). The RUC also compared the code to RUC surveyed, MPC list code 46262 *Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy* (090 day global, Work RVU = 7.49), and backed out all post operative time to reflect a 000 day global procedure. The RUC believed that

the value of the new code was similar to the post operatively stripped 46262 code, and believed the intensity of this new code is comparable to code 92973 *Percutaneous transluminal coronary thrombectomy* (Work RVU= 3.28). The RUC applied a building block approach using the intensity of 92973 after reducing the physician time in the pre-service to a total of 35 minutes from 50 minutes to reflect the typical patient encounter. **The RUC recommends a work relative value of 5.71 for code 37188.**

**In summary, the RUC recommends the following revisions to pre-service time and work relative values:**

New Code	Pre-Service Time	Recommended Work RVU
37184	40	8.66
37185	0	3.28
37186	0	4.92
37187	40	8.03
37188	35	5.71

**Practice Expense**

The RUC accepted the specialty societies’ practice expense recommendations after careful review and minor typographical corrections.

**Saphenous Vein Removal (Tab 16)**

**Gary Seabrook, MD, Society for Vascular Surgery (SVS)**

**Charles Shoemaker, MD, American Society of General Surgeons (ASGS)**

CPT created two new codes and deleted two codes so that the codes describing saphenous vein removal describe current practice. Deleted codes 37720 *Ligation and division and complete stripping of long or short saphenous veins* (work RVU = 5.65) and code 37730 *Ligation and division and complete stripping of long and short saphenous veins* (work RVU = 7.32) describe “complete stripping,” which implied stripping the vein from the calf as opposed to stripping the greater saphenous vein from the saphenofemoral junction to the knee, as is the current practice. A new code was needed because the existing code described a stripping operation that extended all the way to the ankle. Also, code 37720 described two different operations, one for the long saphenous vein and another for the short saphenous vein. CPT created two new codes to describe these different procedures.

The presenters stated that the multispecialty consensus panel reviewed the survey results and determined that the median survey RVW of 9.30 with an IWPOT of 0.134 is too high for 37718. The consensus panel determined that a value of 6.76 RVW, a value significantly below the 25th percentile was more

appropriate based on a comparison with other members of the vein excision family, specifically the most commonly chosen reference services 37765 *Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions* and (work RVU = 7.34) and code 37766 *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions* (work RVU = 9.29). Both codes were evaluated by the RUC in April 2003. In addition, the presenters stated that it is important that the value of 37718 maintain proper relativity with 37722, since 37722 is by far the more common service of this pair. Code 37718 and the reference codes have very similar pre and post service time elements, and the exact office visit pattern:

	<b>37765</b>	<b>37766</b>	<b>37718</b>
Pre-eval time	33	33	35
Pre-position tim	10	10	10
Scrub	15	15	15
Intra-time	60	90	45
Immed Post	25	25	20
99238	0.5	0.5	0.5
99213	1	1	1
99212	1	1	1

The major difference between the 37718 and 37765 is that 37718 has 45 minutes of intra-service time while the reference code 37765 has 60 minutes and 37766 has 90 minutes of intra-service time. Every survey respondent who chose 37765 and 37766 as references cited the intra-service intensity of the new service to be higher than the reference. Making the mathematical downward adjustment for removing intra-time from the reference service, then adjusting the intensity of the remaining minutes upwards by 15% results in a reduction of 2.53 RVUs that must be removed from reference 37766 to account for the intra-service adjustment:

Start with total RVW for 37766:	9.29
Subtract 45 min intra-time	-2.97
15% intensity increment	+0.44
Total RVW base on 37766	6.76

The RUC agreed that the presenters rationale accurately described the physician work involved with code 37766. The presenters also clarified that either code 37765 *Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions* or code 37766 *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions* is typically performed on the same day. **The RUC recommends a work RVU of 6.76 for code 37718.**

37722



The presenters stated that the multispecialty consensus panel had reviewed the survey results and determined that the median survey RVW of 10.00, with an IWPUR of 0.11 is too high for 37722. The panel calculated a value of 7.79 work RVUs, significantly below the 25th percentile based on a comparison with two recently RUC evaluated venous excision reference services.

The first comparison is to a recently evaluated new procedure that accomplishes the exact clinical endpoint, code 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* (work RVU = 6.72). This code and 3772X2 are exactly the same in terms of what they accomplish, which is elimination of the greater saphenous vein. 36475 is for electro-coagulation the vein with radiofrequency and heat, while 37722 is used to report physical excision of the vein.

36475 was not chosen to serve on the reference service list for this RUC survey because it is a 000-day global service, and the presenters stated that since the new codes were 90 day procedures, survey respondents would not be able to make an accurate comparison. However, the consensus panel compared code 36475 data to 37722 because the work involved is very similar. Both services have 40 minutes of pre-service evaluation time and 10 minutes of pre-service positioning time. Code 36475 has 5 minutes more scrub, dress, wait time than 37722 (15 vs 10 min), but 37722 has 5 minutes more immediate post time, so it balances. The two services have identical intra-service times of 60 minutes, and the intra-service intensity of the two services is judged equal by the consensus panel. Both services have one-half of a discharge day. Since 36475 is a 0-day global there are no further elements. 37722 has one 99213 and one 99212 during the 90-day global.

The consensus panel constructed the relative value of 37722 from 36475. The 2005 work RVW of 36475 is 6.72 with pre, intra and immediate post work, which is the same as 37722. Thus, to build a value for 37722 from 36475 the following was calculated:

36475 RVW:	6.72
Add one 99213	0.65
Add one 99212	0.42
Total RVW for 37722 based on 36475:	7.79

The RUC agreed that the presenters rationale accurately described the physician work involved with code 37722 and a work RVU of 7.79 would place the code in proper rank order, especially in comparison to code 37718. The RUC agreed that the presenters rationale accurately described the physician work

involved with code 37766. The presenters also clarified that either code 37765 *Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions or*

code 37766 *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions* is typically performed on the same day. **The RUC recommends a work RVU of 7.79 for code 37722.**

Practice Expense

The RUC recommends standard inputs for these 90 day global procedures performed in the facility setting.

Work Neutrality

The RUC recommends that work neutrality not be applied because the presenters provided compelling evidence that the deleted codes were undervalued. Specifically, the deleted codes were to be included in the five-year review because it was felt that the codes were never properly valued based on the original Hsiao study. However, the codes needed to be changed to specify the removal of the short and the long saphenous veins before the codes could be properly valued. Therefore, instead of reviewing the codes in the Five-Year Review, the codes are being reviewed now because of the deletion and creation of new codes through the CPT process.

**Laparoscopic Gastric Restrictive Procedure, with Gastric Band (Tab 17)**

**Michael Edye, MD, FACS, Society of American Gastrointestinal Endoscopic Surgeons (SAGES)**

**Christine Ren, MD, FACS, American Society of Bariatric Surgery (ASBS)**

The CPT Editorial Panel created eight new codes, 43770 – 43774 and 43886-43888, to describe laparoscopic and open gastric restrictive procedures, with gastric bands.

43770

The RUC reviewed the survey data of approximately 100 bariatric and gastrointestinal endoscopic surgeons. The specialty societies indicated that although code 43843 *Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty* (work RVU=18.62, IWPUT=0.132) was chosen most often as a reference code representing a similar typical patient, the specialty societies felt that the survey respondents did not adequately consider the post-operative work. The specialty societies then used a building block approach, using the intensity from another reference code that was cited by the survey respondents. Using the 25<sup>th</sup> percentile survey time data for code 43770 and an IWPUT of 0.108 from code 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)* (work RVU=27.83, IWPUT=0.108) the specialty societies developed a work RVU of 16.71, which includes the necessary band adjustments. **The RUC accepts**

**the specialty societies' building block approach and recommends a work RVU of 16.71 for code 43770.**

43771

The RUC reviewed the survey data for code 43771 *Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only*. The specialty societies indicated that 43771 involved more pre-service time, as well as a higher intensity of mental effort, technical skill and psychological stress than the reference code 38120 *Laparoscopy, surgical, splenectomy* (work RVU=16.97). The proposed work RVU of 19.50 for 43771 results in an IWPUT of 0.106 which is similar to the IWPUT for the primary procedure for placement of the entire gastric band system (43770 IWPUT=0.108), which includes the necessary band adjustments. **The RUC recommends a work RVU of 19.50 for code 43771.**

43772

The RUC reviewed the survey data for code 43772 *Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only*. The specialty societies indicated that 43772 involved similar pre-, intra- and post-service times, and a higher intensity of mental effort, technical skill and psychological stress than the reference code 44200 *Laparoscopy, surgical; enterolysis* (work RVU=14.42). The specialty societies recommended the survey median work RUV of 15.00, which results in an IWPUT of 0.103 which is slightly lower than the IWPUT for the primary procedure for the placement of the entire gastric band system (43770 IWPUT=0.108). **The RUC recommends a work RVU of 15.00 for code 43772.**

43773

The RUC reviewed the survey data for code 43773 *Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only*. The specialty societies indicated that 43773 involved similar pre-, intra- and post-service times, and a higher intensity of mental effort, technical skill and psychological stress than the reference code 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU=17.22). The specialty societies recommended the survey median work RUV of 19.50, which results in an IWPUT of 0.107 which is slightly lower than the IWPUT for the primary procedure for the placement of the entire gastric band system (43770 IWPUT=0.108), which includes the necessary band adjustments. **The RUC recommends a work RVU of 19.50 for code 43773.**

43774

The RUC reviewed the survey data for code 43774 *Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components*. The specialty societies indicated that 43774 involved more pre-service time, as well as a higher intensity of mental effort, technical skill and psychological stress than the reference code 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)* (work RVU=11.27). The specialty societies recommended the survey median work RUV of 15.00, which results in an IWPUT of 0.106 which is consistent with the IWPUT for the primary procedure for the placement of the entire gastric band system (43770 IWPUT=0.108). **The RUC recommends a work RVU of 15.00 for code 43774.**

43886

The RUC reviewed the survey data for code 43886 *Surgical, gastric restrictive procedure, open; revision of subcutaneous port component only*. The specialty societies indicated that 43886 involved more pre-service time, as well as a higher intensity of mental effort, technical skill and psychological stress than the reference code 36576 *Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site* (work RVU=3.19). The specialty societies recommended the survey median work RUV of 4.00, which results in an IWPUT of 0.029, which is similar to the IWPUT of the reference code (36576 IWPUT=0.031). The higher RVU for 43886 accounts for additional post-discharge office work within the 090-day global period compared to the data for the reference code, which has a 010-day global period. **The RUC recommends a work RVU of 4.00 for code 43886.**

43887

The RUC reviewed the survey data for code 43887 *Surgical, gastric restrictive procedure, open; removal of subcutaneous port component only*. The specialty societies indicated that 43887 involved more pre-service time, as well as a higher intensity of mental effort than the reference code 36590 *Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion* (work RVU=3.30). The specialty societies indicated that the work for 43887 is similar to 36590, with the exception of one additional office visit for 4XXX9 during the 090-day global period. **The RUC recommends a work RVU of 3.95 for code 43887.**

43888

The RUC reviewed the survey data for code 43888 *Surgical, gastric restrictive procedure, open; removal and replacement of subcutaneous port component only*. The specialty societies indicated that 43888 involved less pre-, intra- and post-service time than the reference code 49419 *Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (ie, totally implantable)* (work RVU=6.64). The specialty societies recommended the

survey median RVU of 5.80 for 43888, which results in an IWPUR of 0.054, which is comparable to the IWPUR of a second reference code 36578 *Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site* (IWPUR=0.050). **The RUC recommends a work RVU of 5.80 for code 43888.**

Practice Expense

The RUC assessed and approved the standard 090-day global practice expense inputs with added supplies for band adjustments.

**Diagnostic Rectal Exam Under Anesthesia (Tab 18)**

**Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCRS)**

**Charles Shoemaker, MD, American Society of General Surgeons (ASGS)**

The CPT Editorial Panel created a new code to allow for correct reporting of a diagnostic anorectal exam under general, spinal or epidural anesthesia.

The RUC reviewed code 45990 *Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic* and felt that 45990 involved more pre- and intra-service time and a higher intensity than the reference service code 57410 *Pelvic examination under anesthesia* (work RVU=1.75). Additionally, the RUC observed that the half-day discharge management, 99238 *Hospital discharge day management; 30 minutes or less* should be removed because 45990 has a 000-day global period. The RUC removed the half-day discharge day management, however 18 minutes was added to the seven minutes of immediate post-service time, totaling 25 minutes. The RUC notes that code 45990 would not be reported in conjunction with proctosigmoidoscopies, anoscopies, pelvic examinations under anesthesia and anogenital examinations with colposcopic magnification in childhood for suspected trauma. **The RUC recommends the survey median RVU of 1.80 for 45990.**

Practice Expense

The RUC assessed and approved facility only practice expense inputs for 45990, which was cross-walked from codes 46600 and 45300.

**Open Cryoablation of Renal Tumor (Tab 19)**

**James Regan, MD, American Urological Association (AUA)**

The CPT Editorial Panel created a new code to describe open cryoablation of renal tumors. Open cryoablation of renal tumor(s) is an extension of technology, which is available to treat renal cancers in a select group of patients that include those who have tumors 4cm or less and may be poor surgical candidates, who refuse a radical or a partial nephrectomy, have multiple comorbid illnesses, a solitary kidney or renal insufficiency. Currently, a CPT code exists for laparoscopic surgical ablation of renal mass lesion(s), CPT code 50542, and open cryoablation of liver tumor(s), CPT code 47381, but no specific code exists for open cryoablation of renal tumors.

The RUC reviewed the survey data for 50250 *Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound, if performed* and found that 50250 has similar total time, mental effort, technical skill and psychological stress as its reference code 50542 *Laparoscopy, surgical; ablation of renal mass lesion(s)* (work RVU=19.97). Additionally, the RUC reviewed the IWPUT for this new procedure and found that it is similar to the reference code, 50250 IWPUT=0.061 and 50542 IWPUT=0.073. **The RUC recommends the survey median RVU of 19.97 for 50250.**

Practice Expense

The RUC assessed and approved the practice expense for 50250.

**Ureteral Stent Exchange/Removal (Tab 20)**

**Bibb Allen, MD, American College of Radiology (ACR)**

**Robert Vogelzang, MD, Society of Interventional Radiology (SIR)**

The CPT Editorial Panel created four new codes and revised one code to provide more specificity in the exchange or removal of a ureteral stent. Ureteral strictures and obstructions are relatively common and often treated with the placement of ureteral stents. Ureteral stents are thin catheters threaded into the ureter to divert the urine either internally into the bladder or externally into a collection system. Ureteral stents must be monitored while in place, removed when no longer needed, and changed periodically especially when chronically indwelling. The new family of codes, for the exchange or removal of a ureteral stent (which typically traverses the entire ureter from the renal pelvis to the bladder) differentiates between externally and internally dwelling devices. In addition, the exchange and removal of an indwelling stent, appropriate differentiation is made between a transurethral and percutaneous approach.

### **50382 and 50384**

The RUC first reviewed the survey results presented for new codes 50382 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation (For bilateral procedure, use modifier 50)* and 50384 *Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation*. The RUC believed that for the type of services the recommended median work RVU was too high. The RUC believed the intensity of these procedures was approximately 0.07, and that the 25<sup>th</sup> percentile survey results reflected the true physician work. **The RUC recommends a work relative value of 5.50 for code 50382 and 5.00 for code 50384. In addition, conscious sedation was determined to be inherent in these codes.**

### **50387**

The RUC then reviewed codes 50387 *Removal and replacement of externally accessible transnephric ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation*. Code 50387 was explained to have additional pre-service work in reviewing imaging studies and evaluating the patient, and less time for the actual procedure. The RUC compared the service to code 49423 *Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)* (Work RVU = 1.46) and believed the intensity was greater. The specialties' survey results indicated a median work RVU of 2.63 which the presenters and the RUC believed was too high, however the 25<sup>th</sup> percentile of 1.50 was too low. The RUC believed that a building block approach using the reference code as a base, and adding an additional 0.54 RVUs for the supervision and interpretation (S&I) component of the code should be used to establish the value for 50387. The RUC cited RUC reviewed code 74475 *Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation* (Work RVU = 0.54), as a code that could be used for the S&I portion of the work RVU. **The RUC recommends a work relative value of 2.00 for code 50387. In addition, conscious sedation was determined to be inherent in this code.**

### **50389**

50389 *Removal of nephrostomy tube requiring fluoroscopic guidance (e.g. with concurrent indwelling ureteral stent)* was then reviewed in relation to the other codes in the family, its key reference code, and its survey results. The presenters stated that this new code typically did not require a full diagnostic examination and was less intense than code 50387. The key reference code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (Work RVU = 0.76) was said to be typically billed with a supervision and interpretation code, and was viewed as an

appropriate reference for this new code. The RUC believed the specialties' survey results were consistent for the physician work involved and agreed with the recommended median work value of 1.10 work RVUs. **The RUC recommends a work relative value of 1.10 for code 50389. In addition, conscious sedation was determined to be inherent in this code.**

### **Practice Expense**

The RUC reviewed the practice expense recommendations presented by the specialty society and believed that there was too much clinical labor assistance time in the specialty recommendation. The specialty agreed to eliminate the time of one assistant and to other minor changes to medical supplies.

### **Percutaneous Radiofrequency Ablation of Renal Tumors (Tab 21)**

**Bibb Allen, MD, American College of Radiology (ACR)**

**Robert Vogelzang, MD, Society of Interventional Radiology (SIR)**

In February 2005, the CPT Editorial Panel added one code to adequately describe percutaneous cryotherapy ablation of renal tumors which is an expansion of existing technology to a new anatomic site and tumor type that was not currently described in CPT.

The RUC first reviewed the specialty society's survey results for code 50592 *Ablation one or more renal tumor(s), percutaneous, unilateral; radiofrequency*. The RUC and the presenters believed that the survey results demonstrated that the new service required physician work than liver radiofrequency ablation, code 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* (Work RVU = 15.17). This belief was inaccurate as liver tumor RFA requires significant more time and physician work than 50592. The RUC agreed that a better key reference code is code 20982 *Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance* (Work RVU = 7.27), although slightly more intense. Since the RUC believed key reference code should have been different, the RUC and the specialty thought it would be appropriate to change two components of the surveyed physician time. **The RUC recommends the total pre-service time to equal 30 minutes from 75 minutes, and eliminate the physician work of a level one hospital visit.**

The RUC, based on these physician time changes, a comparison the work and time of 20982, and a building block approach, determined the relative value for 50592.



Building Block Approach

20 minutes of pre-service evaluation and positioning at an intensity of 0.0224 = 0.45

10 minutes of pre-service scrub and dress at an intensity of 0.0081 = 0.08

60 minutes of intra-service work at an intensity of 0.075 = 4.48

30 minutes of immediate post service work with an intensity of 0.0224 = 0.67

½ of a discharge day management service with a RVU = 0.64

1 level two post-operative office follow-up visit with an RVU = 0.43

**RUC recommends a relative work value of 6.75, for code 50592. In addition, conscious sedation was determined to be inherent in this code.**

Practice Expense

The RUC reviewed the practice expense inputs for code 50592 in relation with bone ablation code 20982 and made minor changes in clinical labor time and medical equipment.

Revision-Removal of Vaginal Graft (Tab 22)

**Robert L. Harris, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)**

**George Hill, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)**

**Sandra B. Reed, MD, American College of Obstetricians and Gynecologists (ACOG)**

*RUC member J. Leonard Lichtenfeld, MD, recused himself participating on all ACOG issues.*

The clinical practice involving vaginal reconstructive techniques has expanded and improved to include the use of prosthetic materials. The CPT Editorial Panel created one code to address the surgical problems associated with prosthetic materials that are revised and removed.

The RUC reviewed the specialties' survey results and its rationale for their recommended value. The survey results were well proportioned and supported the recommended physician work value. The specialty calculated the intra-service work per unit of time to be approximately 0.063, which was considered appropriate in comparison to RUC reviewed code 49505 *Repair initial inguinal hernia, age 5 years or over; reducible* (090 day global, Work RVU = 7.59). The RUC also compared code 57295 to RUC reviewed code 46262 *Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy* (090 day global, Work RVU = 7.49) and determined it is also similar in work, complexity, and intensity. The RUC agreed with the specialties' median survey results and recommendation. **The RUC recommends a relative work value of 7.45 for code 57295.**

Practice Expense

The RUC reviewed and agreed with the recommended 090 global standard inputs for code 57295 and agreed to add a second drape sheet under medical supplies.

**Endometrial Sampling (Tab 23)**

**Robert L. Harris, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)**

**George Hill, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG)**

**Sandra B. Reed, MD, American College of Obstetricians and Gynecologists (ACOG)**

*RUC member J. Leonard Lichtenfeld, MD recused himself participating on all ACOG issues.*

The CPT Editorial Panel created an add on code upon request by CMS to the specialty society to provide more specificity to endometrial sampling. Code 58100 *Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method* (work RVU = 1.53), was valued by the RUC as though it was performed in absence of a related procedure (separate procedure), and it was not appropriate to report 58100 with 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s)* (work RVU = 2.20), after the completion of a colposcopy procedure. CMS believed that an add-on code for the endometrial sampling would more appropriately reflect the value of this procedure.

58100 had been surveyed in 2001 and RUC reviewed; the specialty society did not survey then new code, but used an expert panel to develop their recommendation. The RUC reviewed the specialty society's panel recommendation in comparison to code 58100, which included a building block approach. The RUC agreed that the intensity for code 58110 is similar to 58100, and to the following building block approaches, that support the specialty recommended value of 0.77 work RVUs.

**Building Block Approaches used to Support Recommended Work RVU**

- 1) The intra-service work per unit of time of 0.097, from code 58100, multiplied by 10 minutes yields a work relative value of 0.97.
- 2) Beginning with the work relative value of 1.53, from code 58100, and subtracting out the pre-service work of 0.56 RVUs (25 minutes x .0224 IWP/UT), yields a work relative value of 0.97.
- 3) Using 99213 as a proxy for the pre-service time on code 58100, involving 23 minutes of physician time, and subtracting this physician work (work RVU = 0.67) from code 58100 (work RVU=1.53), yields a work relative value of 0.86.

In addition, the RUC and the specialty used the standard payment rules whereby services are usually reimbursed at 50% when a -51 modifier is used to establish the RVU for code 58110. Therefore, 50% of the work RVU of 58100 (Work RVU = 1.53) is equal to 0.77. The RUC agreed with this rationale.

**The RUC recommends a relative work value of 0.77 for new code 58110.**

#### Practice Expense

The RUC reviewed and agreed with the practice expense recommendation presented, and there were no adjustments made.

#### **Intracranial Angioplasty and Stenting (Tab 24)**

**John Barr, MD, American Society of Neuroradiology (ASN)**

**John Wilson, MD, American Association of Neurological Surgeons (AANS)**

**Robert Vogelzang, MD, Society of Interventional Radiology (SIR)**

The CPT Editorial Panel created five new CPT Codes to describe new procedures involving intracranial angioplasty and stenting. Prior to the Panel's action, there were no codes to describe this treatment of patients with impaired cerebral circulation due to arterial narrowing. Angioplasty and stenting of the arteries supplying the brain is more complex than peripheral and coronary angioplasty and stenting cases.

#### 61630 and 61635

The RUC first reviewed codes 61630 *Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous* and 61635 *Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty if performed*. Both codes were reviewed in comparison to their key reference service 61624 *Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord) (000 day global, Work RVU = 20.12)*, their intra-service work per unit of time, and physician time. Several of the surveyed respondents chose the specialty society's reference service as the code that they believed best represented the intensity of this service. The RUC believed that the specialties' survey results were well distributed reflected the intensity of these services. However, the RUC and the presenters agreed, that the specialties' survey results of 61630 and 61635, needed some adjustments in physician time and recommended work value to reflect the typical patient encounter. **The RUC recommends a reduction in the level of one hospital visit from a level two to a level one, and the reduction of the level four office visit to a level three, for codes 61630 and 61635.** These reductions in the levels of post operative visits were used to reduce the physician work recommendation below the surveyed, and specialty recommended, 25<sup>th</sup>

percentile work relative value of 21.50. **In addition, the RUC recommends relative work values of 21.08 for code 61630 and 23.08 for code 61635.**

#### 61640

The presenters stated that CPT Code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel* was surveyed as a 090 day global code prior to the change in the global to a 000 day global code. CMS representatives at the RUC meeting were comfortable with the code having a 000 day global period. The specialty society's survey results reflected the work of a 090 day global code which skewed the median work RVU upward. The RUC compared code 61640 to RUC reviewed code 37216 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection* (090 day global, Work RVU = 17.98), and realized the intensity for the new code was high, but not as high as code 37216. The RUC discussed the specialties' recommended value and believed reductions in physician time and recommended work value were necessary to reflect the 000 day global period and the typical patient encounter. **The RUC recommends the pre-service evaluation and positioning be reduced from 70 and 18 minutes to 45 and 12 minutes respectively.** While agreeing with the pre-service time change specialty society suggested a building block approach consisting of an IWPUT of 0.107, to arrive at the work RVU. The RUC agreed with the intensity recommended by the specialty and from the changes in pre-service time, the RUC used the following building block approach to establish a work relative value for code 61640.

#### Building Block Approach

57 minutes of pre-service evaluation and positioning at an intensity of 0.0224 = 1.28

20 minutes of pre-service scrub and dress at an intensity of 0.0081 = 0.16

90 minutes of intra-service work at an intensity of 0.107 = 9.54

60 minutes of immediate post service work with an intensity of 0.0224 = 1.34

**The RUC recommends a relative work value of 12.32 for code 61640.**

#### 61641 and 61642

The RUC reviewed the two add-on codes 61641 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel; each additional vessel in same vascular family* and 61642 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel; each additional vessel in different vascular family* and believed that the intensity for the codes was justified as there is no surgical rescue for procedural complications that occur in the cerebral vasculature. The RUC agreed that based on the specialty society's survey results indicating a very high intensity, and the RUC reviewed comparison service of 37216 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection* (090 day global, Work RVU = 17.98), the intensity of these two add on codes was

approximately 0.144. The RUC multiplied the physician time in the intra-service period by the agreed upon intensity to arrive at a relative work value for each code. The resulting work RVUs were deemed appropriate even though they were below the median survey results. The RUC and the specialty also agreed that although the survey results indicated pre and post service physician time, the typical patient encounter did not include this time, and it was extracted from the survey results. **The RUC recommends a relative work value of 4.33 for code 61641 and 8.66 for code 61642.**

#### Practice Expense

The RUC approved the standard inputs for all of these facility only codes.

#### **Hyperhidrosis Chemodenervation (Tab 25)**

**Michael Bigby, MD, American Academy of Dermatology (AAD)**

**David Pariser, MD, American Academy of Dermatology (AAD)**

**James Anthony, MD, American Academy of Neurology (AAN)**

The CPT Editorial Panel initially created four codes to describe chemodenervation that is performed specifically for hyperhidrosis. After discussion at the RUC, the specialty society requested that CPT delete codes 64651 *Chemodenervation of eccrine glands; hands, including regional nerve blocks* and 64652 *Chemodenervation of eccrine glands; feet, including regional nerve blocks* until the specialty society provide information to the CPT Editorial Panel to clarify whether these codes are typically performed bilaterally or unilaterally. The CPT Editorial Panel rescinded codes for chemodenervation of hands and feet until they receive a new proposal.

The RUC reviewed code 64650 and the specialty society indicated that the survey times appeared to be high. Code 64650 *Chemodenervation of eccrine glands; both axillae* was crosswalked to 11951 *Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc* (work RVU=1.19). The specialty society adjusted the RVU for 64650 by reducing the pre-service and intra-service time and crosswalking the mental effort, technical skill and psychological stress intensity measures to code 11951. **The RUC recommends a work RVU of 0.70 for 64650.**

The RUC reviewed code 64653 and the specialty society indicated that the survey times appeared to be high. Code 64653 *Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day* was crosswalked to 11921 *Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm* (work RVU=1.93). The specialty society adjusted the RVU for 64653 by reducing the pre-service and intra-service time and crosswalking the mental effort, technical skill and psychological stress intensity measures to code

11921. Code 64653 is more intense than 64650 and maintains rank order. **The RUC recommends a work RVU of 0.88 for 64653.**

Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub, Dress, Wait	Intra-Service	Post-Service	RVU
64650	5	2	0	23	5	0.70
64653	5	2	0	23	5	0.88

Practice Expense

The RUC assessed and approved the practice expense for 64650 and 64653.

**Blepharoptosis Repair, Harvest of Fascia (Tab 26)**

**L. Neal Freeman, MD, American Academy of Ophthalmology (AAO)**  
**Stephen Kamenetzky, MD, American Academy of Ophthalmology (AAO)**  
*RUC chair, William L. Rich, MD, recused himself participating on all AAO issues.*

The CPT Editorial Panel revised two existing codes, 67901 *Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)* and 67902 *frontalis muscle technique with autologous fascial sling (includes obtaining fascia)* to differentiate between repair of blepharoptosis frontalis muscle technique with autologous fascial sling requiring harvesting and blepharoptosis frontalis muscle technique with suture or banked graft.

At the November 2004 CPT Editorial Panel, the specialty society requested that both codes be resurveyed since there was clarification on how the fascia is being obtained and these services had never been reviewed before. Previously 67901 would be reported for either banked fascia or other methods of obtaining grafts. This coding change directs all banked fascia to be reported with 67901 and all autologous fascia be reported with 67902. Typically, the RUC would have expected a work neutrality adjustment. However, the specialty society felt that both codes are currently undervalued. Specialty societies must present compelling evidence in such a review and this was not presented in February 2005.

The specialty society re-presented in April 2005 with compelling evidence available for the change in codes 67901 and 67902 values. Codes 67901 and 67902 had never been RUC reviewed and the difference between the values of the two codes was 0.06, which did not adequately represent the higher intensity of work involved in 67902 when the physician must obtain autologous fascia from the patient.

The revised descriptor for 67901 adds a parenthetical to the existing descriptor. The parenthetical indicates that 67901 is the appropriate code

when banked fascia is used as the suspension device. The revised 67901 is not fundamentally different in terms of pre- or intra-service work when compared to the previous version of 67901. However, an additional 99212 post-operative visit is typical and the RUC accepted 67901 to total four 99212 visits. The specialty society used a building block approach and added an additional 99212 (work RVU=0.43) to the current value for 67901 (work RVU=6.96), which results a work RVU of 7.39. This work RVU value falls slightly below the 25<sup>th</sup> percentile identified by survey respondents. **The RUC recommends a work RVU of 7.39 for 67901.**

The RUC reviewed code 67902, which had only a 0.06 difference in work RVU with 67901. The specialty society used a building block approach to develop a work RVU of 9.35 for 67902. The specialty society used code 20920 *Fascia lata graft; by stripper* (work RVU=5.30). Harvard data lists 20920 pre-service time as 21 minutes for pre-service evaluation time and 25 minutes for dress, scrub, and wait time. Therefore, the pre-service time for 20920 is  $(21 * 0.0224) + (25 * 0.0081) = 0.67$ . Harvard data also lists 20920 post-operative visits as three 99212, one half of a 99231, and one 99238. Therefore, the post-service RVU =  $(3 * 0.43) + (0.5 * 0.64) + (1 * 1.28) = 2.89$ . The intra-service RVUs for 20920 are 5.30 (total) - 0.67 (pre-service) - 2.89 (post-service) = 1.74. The 1.74 represents additional intensity to maintain proper rank order.

The specialty society also indicated that the three 99212 post-operative visits for 67902, listed as Harvard data, did not accurately reflect the postoperative service. A more typical scenario would include three 99212 post-operative visits and one 99213 post-operative visit as supported by survey data. This change adds an additional 99213 visit or 0.65 work RVUs. The specialty society then added 1.74 and 0.65 to the existing work RVUs of 7.02 for 67902, which results in a work RVU of 9.41. However, the specialty society felt that slightly high and recommended 9.35 work RVUs for 67902. This value was between the 25th percentile and the median from the survey data. **The RUC recommends a work RVU of 9.35 for 67902.**

#### Practice Expense

The RUC amended and approved the practice expense for 67901 and 67902.

#### **3D Imaging Rendering (Tab 27)**

**Bibb Allen, MD, American College of Radiology (ACR)**

**Jonathan Berlin, MD, American College of Radiology (ACR)**

The CPT Editorial Panel created two new codes to describe the new technology of volumetric acquisition of advanced cross-sectional imaging. This new technology will address complex renderings such as shaded surface rendering,

volumetric rendering, maximum intensity projections, fusion imaging from multiple modalities and quantitative analysis.

76376

The RUC reviewed the survey results for 76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post-processing on an independent workstation*. The specialty society recommended that the surveyed intra-service time was over-estimated by the survey respondents and felt that the total service time for the surveyed code and the reference code, 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU=1.27), should be the same, 15 minutes. The specialty society recommended that the intra-service time for the surveyed code be 5 minutes. In addition, the specialty society noted that the reference code was deemed far more intense and complex than the surveyed code. Therefore, because the reference code and surveyed code had the same amount of time but vastly different intensities, the specialty society recommended the 25th percentile survey work RVU of 0.20. **The RUC recommends 0.20 Work RVUs for 76376.**

76377

The RUC reviewed the survey results for 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post-processing on an independent workstation*. When evaluating the RVW recommendations for 76376 and 76377, the RUC took into consideration that CPT 74170 *Computed tomography, abdomen; without contrast material followed by contrast material(s) and further sections* (Work RVU=1.40) or other similar CT code will be reported in addition to 76376 or 76377. As an additional reference the RUC compared the combined use of 74170 and 76377 to 74175 *Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing* (Work RVU=1.90) a service previously valued by the RUC that combines computed tomography and three-dimensional rendering techniques to evaluate the abdominal vasculature. The following table indicates that at the recommended value of the 25th percentile, 0.79, the combined RVW recommendation is 0.29 RVU higher than CT angiography of the abdomen and is supported by additional intensity and complexity as well as 8 additional minutes of total time and 2 additional minutes of intra-service time:

	74170	76377	74170 + 76377	74145
Pre-service time		5	10	10
Intra-service time		17	32	30
Post-service time		8	16	10
Total	27	30	58	50
Work RVU	1.40 RVW	0.79 RVW	2.19 RVW	1.90 RVW



\* Total Harvard time  
 \*\* RUC time from 2001

The RUC agreed with the specialty society's recommendation. **The RUC recommends 0.79 Work RVU for 76377.**

Work Neutrality

In addition to the work RVU recommendation, the specialty society acknowledged the fact that new physician work did not drive the creation of new codes. Since the original code descriptor was written, the work of three-dimensional imaging has become much more complex. The evolution of this process has occurred over a number of years and a need for establishing new codes has not arisen until now. The relative undervaluation of complex three-dimensional imaging was mitigated by the preponderance of two-dimensional multiplanar reformatting also described by CPT code 76375. Of the 469,255 cases of CPT code 76375 reported in the 2003 Medicare utilization data, the RUC understands that 80 to 90 percent reflect two-dimensional multiplanar reformatting and only 10 to 20 percent reflect three-dimensional rendering described in codes 76376 and 76377. At the recommended work levels, there should be a net savings in work RVUs to CMS of approximately 38%.

Total 2003 cases of 76375	469,255
Work RVU 76375	0.16
Total RVUs for 76375	75,081
Number of cases of 76376 (10%)	46,925
Number of cases 76377 (10%)	46,925
RVU for 76376	0.20
RVU for 76377	0.79
Total RVU for 76376	9,385
Total RVU for 76377	37,071
Total RVU for 76376 and 76377	46,456
Percent Savings in Work RVUs	38

Practice Expense

The RUC agreed with most of the PE inputs recommended by the specialty society as they conform to the PEAC standards. However, revisions were made to the clinical labor intra-service time and post service time of 76377 to reflect that this procedure would be performed with other procedures. The recommended practice expense inputs are attached to this recommendation.

**Stereoscopic X-Ray Guidance (Tab 28)**

**Louis Potters, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)**

**Najeeb Mohideen, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)**

***Facilitation Committee #1***

The CPT Editorial Panel created a new code to more accurately report stereoscopic x-ray guidance. Stereoscopic x-ray guidance is a relatively new technology that allows physicians to calculate beam attenuation using precise source-to-patient distance data and confirm and position patients for treatment so a more homogenous dose of radiation is delivered to the target volume.

The RUC discussed the physician work valuation of code 77421 *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*.

Representatives from the specialty society began by providing a clear description of this new procedure and the physician work involved. Much of the physician work involves reviewing stereoscopic x-ray images with other images from a treatment planning system or stored CT treatment planning scan data. Other work may involve supervision of patient preparation and providing instructions to the therapists concerning treatment.

The RUC reviewed the survey results carefully and heard statements concerning site visits by CMS. The committee believed that the survey results provided more validity at the 25<sup>th</sup> percentile as a starting point for obtaining a physician work relative value. The committee believed that the 25<sup>th</sup> percentile work relative value of 0.60 should be reduced by the work and time of code 72190 *Radiologic examination, pelvis; complete, minimum of three views* (Work RVU = 0.21) as the time and intensity of 72190 serves as a reasonable proxy for the port films currently performed and work bundled into the weekly radiation therapy service (77427 *Radiation treatment management, five treatments* (Work RVU=3.31)). The physician time for the new code is also recommended by the RUC to be decreased by 6 minutes from the 25<sup>th</sup> percentile of 15 minutes resulting in 9 minutes.

The RUC agreed there is a variable effect on physician work between the radiotherapy code 77427 and stereoscopic X-ray guidance code that requires resolution. This variability is based on the fact that radiation management therapy consists of 5 treatments, whereas the new code can be reported a number of times, typically 3 times. The development of other modalities may

have a different relationship, thus being able to account for physician work changes in the radiation management code. The RUC questions whether this new technology will eventually replace port films and whether CPT/CMS should have considered this as an increase in work within the radiation therapy codes rather than coded separately. This issue requires further evaluation by CPT, CMS and the specialties. **The RUC recommends an analysis of this issue by CMS, CPT, and the specialties.**

**The RUC recommends the following physician work relative value and physician time for code 77421:**

25 <sup>th</sup> Percentile Time	<b>Recommended Time intra and total time</b>	25 <sup>th</sup> percentile RVU	<b>Recommended RVU</b>
15 minutes	<b>9 minutes</b>	0.60	<b>0.39</b>

This issue was referred to CPT Editorial Panel Executive Committee to convene a workgroup to review the best manner to address the potential overlap or unbundling of services with the establishment and increased use of this procedure.

Practice Expense

The RUC recommends that the three minutes associated with the clean room/equipment be removed because there is not any additional time needed for this service as it is billed with other procedures on the same day. The adjustment in physician time has no impact on the clinical staff time as it is not related.

**Intraoperative Consult and Touch Prep (Tab 29)**

**Susan Spires, MD, College of American Pathologists (CAP)**

The CPT Editorial Panel created two new codes to accurately report an intra-operative cytologic evaluation as a single service. Currently, 88161 *Cytopathology, smears, and other source; preparation, screening and interpretation* (Work RVU=0.50) is how this service is being captured. However, 88161 does not take into consideration the increased intensity of effort evaluating cytologies intra-operatively.

88333

The RUC reviewed the specialty society’s survey data and noted that the surveyed code, 88333, when compared to the reference code, 88331 *Cytopathology, evaluation of fine needle aspirate; first tissue block, with frozen section(s), single specimen* (Work RVU=1.19) has slightly higher intensity/complexity measures and an additional two minutes of intra –service time, 25 minutes and 23 minutes, respectively. Therefore, the specialty

society recommended that the median value of their survey, 1.20 work RVUs, be the recommendation for 88333 as this value properly ranks the surveyed code in comparison to the reference code. **The RUC agreed with the specialty society and recommends 1.20 work RVUs for 88333.**

#### 88334

The RUC reviewed the specialty society's survey data and noted that the surveyed code 88334, when compared to the reference code 88332 *Cytopathology, evaluation of fine needle aspirate; each additional tissue block with frozen section(s)* (Work RVU=0.59) has higher intensity/complexity measures and an additional five minutes of intra-service time, 20 minutes and 15 minutes, respectively. Therefore, the specialty society recommended that the median value of their survey, 0.80 work RVUs be the recommendation for 88334 as this value properly ranks the surveyed code in comparison to the reference code. **The RUC agreed with the specialty society and recommends 0.80 RVUs for 88334.**

#### Practice Expense

The RUC reviewed the practice expense inputs recommended for 88333 and 88334. When reviewing the recommendations for 88334, the RUC requested that the 5 minutes attributed to cleaning the room following the procedure should be removed as 88333 and 88334 are performed in conjunction and this activity is already accounted for in 88333.

#### **Multiple Molecular Marker Array-Based Evaluation (Tab 30)**

**Susan Spires, MD, College of American Pathologists (CAP)**

**Raymond Tubbs, DO, College of American Pathologists (CAP)**

**Jeffrey Kant, MD, College of American Pathologists (CAP)**

With the role of inherited mutations in common diseases, such as multiple myeloma breast cancer and colon cancer, the advent of micro array technology has revolutionized the study of genetic abnormalities associated with disease pathogenesis and clinical implications. This type of testing may also be used to interpret, diagnose and monitor disease states, and in screening and preventative medicine to detect carriers or those predisposed to specific diseases. The CPT Editorial Panel created three new CPT codes to quantify the physician effort in the pre-analytic and post-analytic phases of testing, microdissection of lesion for testing, interpretation of test results, integration of multiple test results, and integration with clinicopathologic information (eg clinical history and results from laboratories/histology).

#### 88384

The three tiered codes were developed to describe the physician work and technical costs for array based assays currently available when the code change request was submitted. Subsequent to the development of these codes, the vendor using the technology that the specialty society felt best represented

88384 *Array-based evaluation of multiple molecular probes; 11 through 50 probes* informed the specialty society that their test does not meet the requirements to be considered as an array by the Food and Drug Administration. Although it appears that array-based assays for 11 to 50 probes will soon be forthcoming, the specialty society recommends that it is not appropriate for the RUC to make recommendations regarding 88384 at this time and request this procedure to be carrier priced. The RUC reviewed and agrees with the specialty society's recommendation. **The RUC recommends that 88384 be carrier priced for 2006.**

88385

The RUC reviewed the survey results for 88385 *Array-based evaluation of multiple molecular probes; 51 through 250 probes*. The RUC noted that 88385 when compared to its reference service 88368 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), each probe; manual* (Work RVU=1.40), takes more total physician time (59 and 45 minutes, respectively with similar intensity/complexity measures. Because of the additional time associated with this code, the specialty society recommends 1.50 for 88385. The RUC reviewed this recommendation and felt that this value properly places this service in comparison to the reference code as well as the other pathology services. **The RUC recommends 1.50 work RVUs for 88385.**

88386

The RUC reviewed the survey results for 88386 *Array-based evaluation of multiple molecular probes; 251 through 500 probes*. The RUC was concerned about the low number of survey responses, however, the specialty society explained that the frequency for these procedures is very low, 300 times per year. However, due to the low number of responses the specialty societies felt that the survey results were not reflective of the work associated with this procedure. Therefore, the specialty society's expert panel compared this code to 88385 and felt that 88386 required 25% more work than 88385 which represents a work RVU of 1.88 for this procedure. The RUC reviewed this recommendation and felt that this value properly places this service in comparison to 88385 as well as other pathology services. **The RUC recommends 1.88 work RVUs for 88386.**

RUC Re-Review

The specialty society requests that these codes be reviewed for changes in work or practice expense once this new technology become widely dispersed. **The RUC requests that these codes be re-reviewed in time certain of 2 years.**

Practice Expense

The RUC reviewed the practice expense inputs recommended by the specialty society. The RUC agreed with the recommended values.

**Needle EMG with Chemodenervation (Tab 31)**

**Andrea Boon, MD, American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM)**

**Benn Smith, MD, American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM)**

**James Anthony, MD, American Academy of Neurology (AAN)**

**Robert Goldberg, MD, American Academy of Physical Medicine and Rehabilitation (AAPM&R)**

***Facilitation Committee #1***

CPT created two new codes for guidance in conjunction with chemodenervation. Existing codes 64612 *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)*( work RVU = 1.93), 64613 *Chemodenervation of muscle(s); cervical spinal muscle(s) (eg, for spasmodic torticollis)* (work RVU = 1.96), and 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* (work RVU = 2.20) were also reviewed because the presenters were requesting to change the values of these codes. During the presentation it was clarified that the new codes would not be used with 64612 since guidance is not used. Therefore the RUC suggested that CPT remove the reference to 64612 from the parenthetical for code 95874. The RUC then voted to withdraw code 64612 from consideration of the work RVU. The RUC examined the data for 64613 and 64614 and concluded to maintain the current values. The RUC also discussed the possibility that these codes contained needle guidance work. Only code 64614 has been reviewed by the RUC and after reviewing both the RUC rationale as well as the PEAC approved inputs, the RUC could not determine conclusively if the work value actually included the guidance work. The PE inputs included a nerve stimulator machine but it appeared that the code was reviewed as part of a large submission by the North American Spine Society whose members are not the dominant provider of the service, and the inclusion may have been in error. In order to obtain the proper value for both codes based on accurate vignettes, the RUC felt that both codes should be included in the Five-Year Review. CMS will conclude whether to add these codes to the Five-Year Review.

**The RUC supports the specialty societies' request to CMS to submit codes 64613 and 64614 in the Five-Year Review.**

For the new guidance codes 95873 and 95874, the RUC concluded that the survey respondents overestimated the work involved in the guidance. The RUC examined reference code 95860 *Needle electromyography; one extremity with or without related paraspinal areas* (work RVU = 0.96, intraservice time = 34 minutes). The RUC determined that the intensity for the new procedures and the reference procedure were the same so a proper value for both new codes should be based on the ratio of time with the

reference code. Therefore, the new codes' survey intra-service times of 20 minutes divided by the reference code time of 34 minutes was multiplied by the reference value of 0.96 resulting in a recommended work RVU of 0.56 for both codes. This value would place the new codes in proper rank order with the reference code.

**The RUC recommends a work RVU of 0.56 for codes 95873 and 95874.**

Practice Expense

The RUC agreed to five minutes of clinical staff assist time and several additional supplies and equipment that would be used for the add-on codes 95873 and 95874. For codes 64612, 64613, and 64614, the RUC revised the PE inputs to specify the individual supplies used rather than the basic injection pack.

**Complex EMG (Tab A)**

**Benn Smith, MD, American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM)**

**James Anthony, MD, American Academy of Neurology (AAN)**

**Robert Goldberg, MD, American Academy of Physical Medicine and Rehabilitation (AAPM&R)**

CPT created two new codes for identifying and grading the severity of disorders of nerve and muscle that affect the larynx and diaphragm because the existing codes do not accurately describe the physician work involved in these more difficult electromyographic procedures. Current needle electromyography codes do not appropriately reflect the difficult, time-consuming, risky procedure of laryngeal electromyography and diaphragm electromyography. These procedures are done in sensitive areas. The current RUC evaluations for other electromyography codes, although appropriate for what they define, are not appropriate for these riskier, more difficult electromyographic procedures. These proposed new codes would allow physicians to properly code laryngeal electromyography and diaphragm electromyography. The RUC agreed to maintain the values of the existing codes 95867, 95868, 95870 because the RUC agreed with the presenters who stated that the new services would have accounted for less than one half percent of the volume of the existing codes. Therefore, work neutrality should not apply to this family of codes.

For the new codes, the RUC examined the survey data and agreed with the presenters that that the median survey values appropriately valued the physician work. Both codes were compared to reference code 95860 *Needle electromyography; one extremity with or without related paraspinal areas* (work RVU = 0.96, total time of 34 minutes). While the new codes have total times similar to the reference code, the RUC agreed that the intensity of the

new codes was significantly higher and therefore the new codes warranted higher RVUs. **The RUC agreed that a work RVU of 1.57 for code 95865 and 1.25 for 95866 would place the codes in proper rank order.**

#### Practice Expense

Practice expenses were revised to reflect that the clinical staff assist physicians for two-thirds of the physician intra-service time.

#### **Education and Training for Patient Self-Management (Tab B)**

The CPT Editorial Panel created three new codes to describe educational and training services prescribed by a physician and provided by a qualified, non-physician healthcare professional. There is no physician work associated with these services. The RUC considered recommendations for direct practice expense inputs only. The RUC reviewed inputs for CPT code 98960 *Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient*, 98961 *2-4 patients* and 98962 *5-8 patients*. **The RUC assessed and modified the practice expense inputs, which are attached to this recommendation.**

#### **Moderate (Conscious) Sedation (Tab C)**

**Steven Krug, MD, American Academy of Pediatrics (AAP)**

**Charles Mick, MD, North American Spine Society (NASS)**

**Timothy Shahbazian, DDS, American Academy of Oral and Maxillofacial Surgeons (AAOMS)**

***Facilitation Committee #3***

The CPT Editorial Panel created six new codes to accurately report the two separate families of moderate sedation distinguished by provision of moderate sedation services by the physician who is performing the diagnostic or therapeutic service and supervising an independent trained observer; or moderate sedation services performed by a physician (other than an anesthesiologist) other than the physician performing diagnostic or therapeutic service. These codes would consist of two separate time-based base codes in each family, distinguished by patient age, with a single add-on code in each family to report additional time. These new codes replace CPT codes 99141 *Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation*, (work relative value = 0.80) and 99142 *Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal* (work relative value = 0.60).



The CPT Editorial Panel and the RUC have reviewed the moderate sedation issue over the past five years. This work included development of an appendix in CPT to identify the services in which moderate sedation is an inherent component. The practice expense refinement has resulted in consistent direct practice expense inputs for the provision of the sedation in each of these codes. CPT instructions note that CPT codes 99143 – 99145 may not be used in addition to the codes listed in the appendix, as the resources utilized in providing these services have already been included in the procedure code. In addition, CPT instructions indicate that 99148 – 99150 may not be reported with the codes listed in the appendix when performed in the non-facility as the resources for this site-of-service are incorporated in the procedure code.

The RUC also continues to advocate that CMS consider a change in payment policy to allow separate payment for conscious sedation, utilizing the stand-alone CPT codes 99143 – 99150, when this service is provided in conjunction with a procedure where conscious sedation is not an inherent component. We welcome the opportunity to retrospectively review utilization data once these codes are active to review data regarding the procedure codes that are routinely reported with moderate sedation codes. The RUC understands that 99143 – 99150 will be reported with codes for procedures where conscious sedation is not inherently a part of the procedure. This is to be taken into consideration in reviewing the relative value recommendation for these new moderate sedation codes. The provision of sedation would not be the normal course of action and that implies a different intensity of work for these services than would be the case when it is inherent to the procedure.

The RUC first reviewed the code family describing the provision of moderate sedation services by a physician other than the physician performing the diagnostic or therapeutic service:

#### 99149

The RUC reviewed the specialty societies' recommendations to the RUC for 99149 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time.* The specialty societies reviewed the survey time data and felt that the RVU value reflected in the survey data was over-valued. Therefore, the specialty societies recommended using a building block methodology. This methodology included using the surveyed pre, intra and post service times, 15, 20 and 15 minutes respectively.

The RUC agreed that the pre-service work was comparable to 99241 *Office consultation for a new or established patient* (23 minutes total time, Work

RVU=0.64). The RUC agreed with the specialty society recommendation to consider the majority of the intra-service time as related to monitoring. This monitoring time was felt to be similar in intensity to the anesthesia intensity level 2 (0.031) approved for 19 anesthesia services utilized in the previous Five-Year Review. The RUC agreed that five minutes of elevated intensity was appropriate for the induction period. Although the RUC was comfortable with the time allotted for post-service time, 15 minutes, the RUC felt that using the full value for 99241 in the pre-service work would lead to a duplication in the post-service time work (as 99241 includes 4 minutes of post-service time). Therefore the RUC recommended that 4 minutes of time at the usual post-service IWPUT of 0.0224 be removed from the specialty societies recommended post-service time work value. This time change was reflected in the following building block methodology:

Pre-service median time	15 minutes Pre-service reference code: 99241	0.64
Intra-service time	20 minutes: 5 minutes for induction (0.057) 15 minutes of monitoring (0.031)	0.29 0.47
Post-service median time	11* minutes of post-service intensity (0.0224) (*15 minutes less 4 minutes of post-service time already built into the 99241 code)	0.25
<b>Total</b>		<b>1.65 RVUs</b>

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service **The RUC recommends a work RVU of 1.65 for 99149.**

99148

The specialty societies' recommendation for this procedure 99148 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time* was based on the extrapolation of the relationship between "under age five" and the "five and over" central venous access codes (36555-36571). The specialty society determined the relative relationship between the pediatric and non-pediatric central venous access codes to be approximately 1.065. The specialty society applied this scaling factor to the 99149, 1.65 work relative value, which results in a work RVU recommendation of 1.75 work RVUs for 99148.

RUC recommended Work RVU for 99149	1.64
Specialty Society Scaling Factor from central venous access code age differentiation	x 1.065
Specialty Society Recommended Work RVU of 99148	1.75

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service **The RUC recommends a work value of 1.75 for 99148.**

99150

The specialty societies' recommendation for this procedure 99150 *Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; each additional 15 minutes intra-service time or Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; each additional 15 minutes intra-service time includes multiplying the 15 minutes of intra-service time the same intensity utilized for monitoring time in the base code (0.031).*

Specialty Society Recommended Intra-Service Time	15 Minutes
Monitoring intensity as described in 99149	0.031
Specialty Society Recommended Work RVU	0.47

The RUC reviewed this methodology and felt that it accurately captured the intensity and complexity of this service. **The RUC recommends a work relative value of 0.47 for CPT code 99150.**

99144

The RUC discussed 99144 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time.* The RUC felt that there should be a reduction in the intensity associated with the pre and post-service times of this code. The specialty society agreed that the intensity of the pre and post service time should be reduced by 50% (from 0.0224 to 0.0112) to account for the duplicative work associated when this service is performed with another procedural code by the same provider. However, the specialty society did state that they tried to account for this duplication by decreasing the surveyed pre-service time of 15 minutes to 10 minutes. As the intensity decrease will now account for this duplication, the specialty society requested that the surveyed pre-service time of 15 minutes be reinstated. In addition, the specialty societies explained that the intra-service work for the new code should reflect a 50% reduction in the intra-service work calculated for 99149 (RUC Approved work relative value for intra-service = 0.76) to account for the multiple procedures performed by a single provider, resulting

in an intra-service work RVU of 0.38. Therefore, the following times and intensities were used to develop the RUC’s recommendation of 0.66 work relative value for 99144.

Pre-Service	15 minutes x 0.0112	0.168
Intra-Service	(5 minutes x 0.057 + 15 minutes x 0.031) x 0.50	0.380
Post Service	10 minutes x 0.0112	0.112
	Total	0.66

**The RUC recommends a work relative value of 0.66 for 99144.**

99143

The RUC discussed 99143 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time.* The specialty societies based their work recommendation for this code on the extrapolation of the relationship between the “under age five” and “the five and over” central venous access codes (36555-36571). The specialty society determined the relative relationship between the pediatric and non-pediatric central venous access codes to be approximately 1.065. The specialty society applied this scaling factor to the newly recommended work RVU of 99144, 0.66 RVU which results in a work RVU recommendation of 0.70 for 99143. The RUC agrees that this is appropriate as it is also the mean of the work relative values from the codes that previously were utilized to report this service 99141 (work relative value = .80) and 99142 (work relative value = 0.60).

Facilitation Committee Recommended Work RVU for 99144	0.66
Specialty Society Scaling Factor from central venous access code age differentiation	x 1.065
Facilitation Committee Recommended Work RVU for 99143	0.70

**The RUC recommends a work relative value of 0.70 for 99143.**

99145

The RUC discussed 99145 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status, age 5 years or older; each additional 15 minutes intra-service time.* The specialty societies agreed that this procedure should be crosswalked to 99150 however, they felt that to account for the multiple procedures being performed

by a single provider the intensity associated with 99150, 0.031, should be reduced by 50% resulting in an intensity of 0.0155. This new value should be applied to the 15 minute increment of intra-service time for this procedure resulting in a work relative value of 0.23.

Specialty Society Recommended Intra-Service Time	15
50% reduction of the Intensity of Intra-Service Work of 99150	0.0155
Facilitation Committee Recommended Work RVU for 99145	0.23

**The RUC recommends a work relative value of 0.23 for 99145.**

Practice Expense:

The practice expense inputs were reviewed by the RUC. Modifications were made to the specialty societies' recommendations to reflect PEAC standards for conscious sedation.

**Continuing Neonatal Intensive Care Services (Tab D)**

**Gilbert Martin, MD, FAAP, American Academy of Pediatrics (AAP)**

**Richard Molteni, MD, FAAP, American Academy of Pediatrics (AAP)**

The CPT Editorial Panel has recognized that the physician work involved in the provision of neonatal intensive care services is different from that typically provided to older infants, children and adults. Physician services in neonatal and pediatric intensive care units are provided by full time physicians who are hospital based. They care for patients of various maturity, birth weight, gestational age and level of critical/intensive care. All of these patients require intensive monitoring and oversight, however, not all of these patients qualify for critical care services as currently defined by CPT but all require frequent visits, team appraisals, laboratory and imaging studies, physical exams and communication with parents and family. These codes will bridge the gap and complete the neonatal critical and intensive care codes for neonates with present body weight of 2501-5000 grams.

The RUC reviewed the specialty society's survey results for 99300 *Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)* and determined that the reference code 99299 *Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)* (Work RVU=2.50) was reasonable. When comparing the surveyed code to reference code, it was determined that both codes had the same intra-service times, 30 minutes. In addition, the surveyed code and the reference code had similar intensity and complexity measures. Therefore, the specialty society recommends the survey median of 2.40 work RVUs which reflects an appropriate difference for a slightly higher weight patient. The RUC reviewed the survey data and agrees with the specialty society's recommendations. **The RUC recommends 2.40 work RVUs for 99300.**

### **Practice Expense**

As this procedure is performed in the facility setting only, no practice expense inputs are recommended.

### **Nursing Facility Services (Tab E)**

**Dennis Stone, MD, American Medical Directors Association (AMDA)  
Facilitation Committee #4**

The CPT Editorial Panel replaced the existing family of codes for nursing facility services (CPT codes 99301 – 99313) with a new family of codes, representing a greater range in the complexity of medical decision making. The Panel specifically created CPT Code 99310 (BBB7) *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention* to describe a new higher level visit in the subsequent visit family of codes.

A survey was conducted for this new family of codes. Unfortunately, the specialty was not able to include important, relevant reference services (such as hospital visits) because many of the Evaluation and Management services are currently under review in the Five-Year Review of the RBRVS. The RUC reviewed the resulting data and found it to be unacceptable and does not recommend a new survey until the specialty is able to include other Evaluation and Management services, such as the hospital visit codes on a reference service list.

The specialty societies presented an alternative approach to value the new nursing facility services based on a crosswalk from the existing nursing facility services, with new work described for the new comprehensive subsequent visit code 99310 (BBB7). The specialty society indicated that they plan to re-survey these services after the hospital visit work relative values are considered stable and may be used as reference services. The specialties presented, and the RUC agreed, to the following relative values:

Current Nursing Facility CPT Code (To be deleted in 2006)	2005 Work RVU	New Nursing Facility CPT Code (Tracking #)	Recommended Work RVU
99301	1.20	99304 (BBB1)	1.20
99302	1.61	99305 (BBB2)	1.61
99303	2.01	99306 (BBB3)	2.01
99311	0.60	99307 (BBB4)	0.60
99312	1.00	99308 (BBB5)	1.00
99313	1.42	99309 (BBB6)	1.42
		99310 (BBB7)	1.77
99301	1.20	99318 (BBB8)	1.20

New CPT code 99310 (BBB7) describes a visit with at least two of these three key components: comprehensive history, comprehensive examination, or medical decision making of high complexity. This mirrors the elements required in a 99215 *Level 5 Established Patient Office Visit* (work RVU = 1.77) and the RUC recommends that this is an appropriate crosswalk for the new nursing facility service.

The RUC acknowledged that the valuation of 99310 (BBB7) represents new physician work not currently captured in this family of services. The committee agreed that there is compelling evidence that patient population has changed for these services as this new comprehensive code relates to patients who would have previously been routinely hospitalized. The committee also notes that there has been a shift in patient acuity as referenced in studies discussed in the attached letter.

The surveyed physician time should be used as an interim approach until the specialties re-survey these services. It is acknowledged that this time, and in particular the post-service time may be inappropriate as there was confusion regarding the current heading of “day of procedure” preceding the time data questions in the RUC survey. The committee recommended that an asterisk be placed on these services so that the time data for these services are not used for any other validation purposes. In addition, the committee recommended that this time data be re-examined, along with the new survey time, when these codes are reviewed again in the future. The RUC will recommend that CPT refrain from including intra-service time in CPT for these services until after a new survey is reviewed.

#### Practice Expense

The direct practice expense inputs for nursing facility services were reviewed by the RUC in March and April 2004. Therefore, the RUC did not agree with the specialty society’s recommendation to increase the clinical staff time for these services. The RUC recommended practice expense inputs represent the current practice expense related to the current nursing facility services and are attached to this recommendation.

**Domiciliary Care Services (Tab F)**

**George Taler, MD, American Academy of Home Care Physicians (AAHCP)**

***Facilitation Committee #4***

When CPT Editorial Panel convened an E&M workgroup to evaluate potential changes in CPT descriptors, a review of all the E&M codes was conducted. Several coding changes were proposed. Restructuring of the nursing facility codes was recommended as was deletion of the domiciliary care codes. The CPT Editorial Panel considered the work and practice expense of the domiciliary codes to be identical to the Home Visit codes (CPT codes 99341-99350) and felt it would be less confusing for providers to use a single family of codes to describe these services. When this was proposed, objections were raised by the Centers for Medicare and Medicaid Services (CMS) because the definition of a domiciliary facility did not include a private home. Because of this administrative restriction, restructuring of the domiciliary codes was proposed. The domiciliary codes were revised to have a structure identical to the home visit codes. Following this, the home care physicians were asked to survey these codes. The previous valuations of these codes by CMS were arbitrarily assigned as 67% of the home visit codes.

The RUC agreed to the following:

1. Home Visits and Domiciliary Care Services are analogous services with essentially identical physician work and practice expense.
2. Domiciliary Care Services codes were developed to address a CMS administrative problem since CMS would not allow deletion of these codes.
3. The equivalence of the home visit and domiciliary codes constitutes compelling evidence that CMS used a flawed assumption by assigning the domiciliary codes 67% of the value of the home visit codes. Further compelling evidence is outlined in the attached letter prepared by the presenting specialty societies.
4. The survey results were hopelessly flawed and would not be useful in accurately capturing the physician work involved in these services (i.e. the vignettes were not felt to be typical by 50% or more of respondents; intra-service times did not correlate with similar level home visit codes).

Therefore, the RUC recommends the following:

1. Discard the survey data and crosswalk the physician work and practice expense values for analogous Home Visit code levels, as CPT had originally proposed.
2. A note should be included in the RUC Database describing the straight crosswalk from the home visit codes.



3. Recommend to CPT that the typical times used for domiciliary visits in the CPT book should be identical to the times used for home visits.

**The RUC recommends the following physician work relative values and physician time:**

Code	Description	Work RVUs	CPT Times	Domiciliary Care Codes	Recommended Domiciliary Care Code Work RVU	Recommended Domiciliary Care Code Time
99341	Home visit, new patient	1.01	20	<b>99324</b>	<b>1.01</b>	<b>20</b>
99342	Home visit, new patient	1.52	30	<b>99325</b>	<b>1.52</b>	<b>30</b>
99343	Home visit, new patient	2.27	45	<b>99326</b>	<b>2.27</b>	<b>45</b>
99344	Home visit, new patient	3.03	60	<b>99327</b>	<b>3.03</b>	<b>60</b>
99345	Home visit, new patient	3.78	75	<b>99328</b>	<b>3.78</b>	<b>75</b>
99347	Home visit, est patient	0.76	15	<b>99334</b>	<b>0.76</b>	<b>15</b>
99348	Home visit, est patient	1.26	25	<b>99335</b>	<b>1.26</b>	<b>25</b>
99349	Home visit, est patient	2.02	40	<b>99336</b>	<b>2.02</b>	<b>40</b>
99350	Home visit, est patient	3.03	60	<b>99337</b>	<b>3.03</b>	<b>60</b>

Practice Expense:

The RUC recommends a straight cross-walk of the practice expense inputs of the Domiciliary Care codes to the Home visit codes as described in the table above. These practice expense inputs are attached to this recommendation.

**Care Plan Oversight (Tab G)**

**Steven Krug, MD, American Academy of Pediatrics (AAP)**

**Meghan Gerety, MD, American Geriatric Society (AGS)**

The limitation of the existing care plan oversight codes for children and adults with special health care needs is not in the definition of the service, but in the restriction on setting – patients must be under the care of a home health agency, in hospice or in a nursing facility. While a significant number of children and adults with special health care needs and chronic medical conditions for the care model and the care plan oversight service code requirements that the patient be under the care of a multidisciplinary care modality, many patients are not under the care of a home health agency, in a hospice or in a nursing facility. Thus the limitation of the care plan oversight codes is not in the definition of the typical activities and services provided, but in the restriction on setting and circumstance. Therefore, the CPT Editorial Panel created two new codes to address this limitation of the existing care plan oversight codes.

99339

The RUC reviewed the survey results of 64 pediatricians, geriatricians and home care physicians in regard to the valuation of 99339 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest*

*home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes* and determined that the reference code 99374 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes* (Work RVU=1.10) was reasonable. When comparing the surveyed code to the reference code, it was determined that the surveyed code has more total time than the reference code, 40 and 34 minutes respectively. Furthermore, the RUC recognized that the surveyed code required more mental effort, and judgment and higher technical skill than the reference code. Therefore, due to increased times and greater intensity and complexity measures, the RUC recommends the median survey value of 1.25 work RVUs for 99339. The RUC agreed with the specialty societies' recommendation and felt that this value appropriately places this service relative to other procedures. In addition, the specialty societies recommended and the RUC agreed that it is reasonable to expect that the proposed work values should be more than the existing care plan oversight codes because of an absence of a home health agency to provide organizational support for the physician. **The RUC recommends 1.25 work RVUs for 99339.**

#### 99340

The RUC reviewed the survey results of 61 pediatricians, geriatricians and home care physicians in regard to the valuation of 99340 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a*

*calendar month; 30 minutes or more and determined that the reference code 99375 Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for the purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more (Work RVU=1.73) was reasonable. When comparing the surveyed code to the reference code, it was determined that the surveyed code has more total time than the reference code, 60 and 57 minutes respectively. Furthermore, the RUC recognized that the surveyed code required more mental effort, and judgment and higher technical skill than the reference code. Therefore, due to increased times and greater intensity and complexity measures, the specialty societies recommend the median survey value of 1.80 work RVUs for 99340. The RUC agreed with the specialty societies' recommendation and felt that this value appropriately places this service relative to other procedures. In addition, the specialty societies recommended and the RUC agreed that it is reasonable to expect that the proposed work values should be more than the existing care plan oversight codes because of an absence of a home health agency to provide organizational support for the physician. **The RUC recommends 1.80 work RVUs for 99340.***

#### Practice Expense

The specialty society recommended that the practice expense inputs for the new codes, 99339 and 99340, be crosswalked to the existing care plan oversight codes 99374 and 99375. The RUC agreed with this crosswalk. The practice expense recommendations are attached to this report.

#### **Inpatient Follow-Up and Confirmatory Consultations (Tab H)**

At the November 2004 CPT Editorial Panel Meeting, the Panel acted to delete the inpatient follow-up consultation (CPT code 99261-99263) and the confirmatory consultation (CPT codes 99271-99275) services for *CPT 2006*. The services previously reported by these codes will now be reported by subsequent hospital visit codes (99231-99233) or other evaluation and management codes, as appropriate.

In analysis conducted in preparation for the CPT Editorial Panel meeting, it was estimated that the total impact of this coding change for Medicare would be approximately \$30,000,000. The increase in the total work relative values

for the subsequent hospital visit codes is less than 1%. If a work neutrality adjustment was implemented to the subsequent hospital visit codes, it would be minimal, as follows:

	<u>2005 Work RVU</u>	<u>Work RVU adjusted</u>	<u>Change</u>
99231	0.64	0.64	0.00
99232	1.06	1.05	0.01
99233	1.51	1.50	0.01

At the February 2005 RUC meeting, the RUC briefly discussed the work neutrality implications of deleting the inpatient follow-up and confirmatory consultation CPT codes in CPT with cross-references to report other existing CPT codes. The RUC understands that CMS will have the work neutrality impact analysis complete by the April RUC meeting. The RUC agreed to discuss this issue at that time.

CMS staff had reviewed this issue and responded as follows:

*I reviewed the proposed changes and do not see any reason to apply a budget neutrality factor to these services. The increase in total WRVUs is so small that a budget neutrality adjustment is not warranted.*

It appears that the CPT analysis may have overestimated the true impact and CMS does not view this to be a budget neutrality issue. The RUC, therefore, does not need to take any further action on this issue.

## XII. Practice Expense Review Committee Report (Tab I)

Doctor Moran reminded the members that the business of the PERC is still evolving, and that under the current PERC process, when there is a presenting physician at the PERC meetings all practice expense issues are quickly and completely resolved. However, when a physician presenter is not present, the PE issues are not easily resolved. The PERC wanted the RUC to know that a presenting physician from the society is extremely helpful to the entire PERC process.

The PERC's main business consisted of a review of the practice expense inputs of a few existing codes and all new and revised codes brought forth during this RUC meeting. The PERC first discussed the six existing codes that were considered special practice expense requests, and then reviewed all the new and revised codes' practice expense inputs.

The PERC made recommendations on two of the six existing codes reviewed. These two codes were requested by the American College of Cardiology and

CMS for refinement. The PERC refined the two codes (93271 and 93012) and made their recommendations to the RUC.

The RUC accepted all the recommendations made by the PERC and these recommendations are reflected in the full PERC report and in the RUC recommendations. In addition, Doctor Rich thanked the entire PERC for its efforts at facilitating the review of practice expenses for the RUC. **The RUC approved the PERC's recommendations, and its full report is attached to these minutes.**

### XIII. RUC HCPAC Review Board Report (Tab J)

Robert C. Fifer, PhD, HCPAC Alternate Co-Chair, briefed the RUC on the April 2005 HCPAC meeting. Dr. Fifer indicated that Mary Foto, OTR, was re-elected to remain the HCPAC Co-Chair for a second two-year term and the HCPAC re-elected Dr. Fifer to remain the HCPAC Alternate Co-Chair for a second two-year term.

#### Professional Liability Insurance (PLI)

Dr. Fifer announced that the HCPAC discussed the appropriateness of PLI crosswalk assumptions. The RUC requested the PLI risk factor be set to 1.00 (\$6,100) for eight health professions. The RUC also invited these professions to present evidence that their annual PLI premiums are greater than \$6,100. These professions include:

- Clinical Psychologist
- Licensed Clinical Social Worker
- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

**The HCPAC professions indicated agreed to make their best effort to gather information on the collection of PLI premium data and submit it to RUC HCPAC staff by September 1, 2005 to be discussed at the September 2005 RUC HCPAC meeting.**

#### Gait and Motion Analysis (96000-96003)

Dr. Fifer indicated that in April 2001, the RUC HCPAC Review Board reviewed the gait and motion analysis codes 96000-96003, brought forth by the American Physical Therapy Association (APTA). The HCPAC concluded that the vignettes needed to be clarified for the services provided prior to

conducting a survey. In January 2002, the HCPAC reviewed the surveyed gait and motion analysis codes. However, due to a flaw in the survey process the validity and accuracy of these codes were questioned. The HCPAC recommended maintaining the current values assigned by CMS until more accurate survey data could be obtained. The APTA added that they would consult the Clinical Gait and Movement Analysis Society for further information regarding the time data. The Clinical Gait and Movement Analysis Society was contacted and flawed survey data was received.

At this meeting, Jim Nugent from APTA indicated that no action on the work values will be made at this time. APTA will be examining description and work involved in the facility and non-facility settings and will bring codes 96001-96003 to CPT in approximately two years. The HCPAC recommends that 96000, 96001, 96002 and 96003 be identified as under CPT Review in the database.

#### Five-Year Review Issues

Dr. Fifer indicated that two codes will be coming to the HCPAC in the September 2005 Five-Year Review: 11730 *Removal of nail plate* and 29580 *Application of paste boot*. The American Speech-Language-Hearing Association has also submitted a comment pertaining to all audiology and speech pathology codes. *Staff Note: The Five-Year Review Workgroup has recommended that a letter be sent to CMS requesting that CMS clarify the payment policies related to this issue by May 15 or this issue may not be able to be addressed in this Five-Year Review.*

#### **HCPAC Relative Value Recommendations for CPT 2006**

In addition, the HCPAC reviewed the recommendations for Auditory Rehabilitation Assessment, Psychological Testing Exam and Neurobehavioral Status Exam. The HCPAC recommended that the current work values and practice expense inputs for the Auditory Rehabilitation Assessment, CPT codes 92506, 92507 and 92508 be maintained. The practice expense for the additional Auditory Rehabilitation Assessment codes, 926X1, 926X2, 926X3 and 926X4, were assessed, modified and approved by the HCPAC. Additionally, for guidelines on defining time for 926X1 and 926X2 the HCPAC requested that CPT add the following parenthetical: (When reporting 926X1, 926X2 use the face-to-face time with the patient or family). Addition of the parenthetical is contingent upon CPT acceptance.

The HCPAC assessed, modified and approved the code descriptors, physician work and practice expense inputs for the Psychological Testing Exam codes, 9610X, 9610X1, 9610X2. Additionally, the HCPAC assessed, modified and approved the code descriptors, physician work and practice expense inputs for the Neurobehavioral Status Exam codes, 9611X, 9611X1, 9611X2, 9611X3.

These recommendations are included in the RUC HCPAC Review Board Report.

**The full report of the RUC HCPAC Review Board Report was accepted for filing and is attached to these minutes.**

XIV. Research Subcommittee (Tab K)

Research Subcommittee Report

Doctor Borgstede presented the research subcommittee report and discussed the alternative methodologies that the subcommittee reviewed. Doctor Borgstede first recommended that the RUC approve the STS proposed five-year review alternative methodology that was discussed at the February RUC meeting and again via conference call prior to the April RUC meeting.

**The Subcommittee recommended and the RUC approved the STS methodology as outlined below:**

**RUC Summary Form Data Table**

<b>Presenter(s):</b>	STS Advisor	
<b>Specialty(s):</b>	STS	
<b>CPT Code:</b>	Per LOI	
<b>Sample Size:</b>	STS Database - Number of patient records utilized for review	
<b>Sample Type:</b>	STS Database and CTS Expert Panel	
<b>1.</b>	<b>Survey RVW:</b>	Utilize the building block methodology (BBM) to calculate an RVW.
<b>2.</b>	<b>Pre- Evaluation Time</b>	Each pre-service time component will be developed by the CTS Expert Panel after reviewing the range of pre-service times in the RUC database for RUC-reviewed procedures. A rationale for the times developed will be provided that includes comparison to codes requiring similar physician work.
	<b>Pre- Positioning Time</b>	
	<b>Pre- Scrub, Dress, Wait Time</b>	
<b>3.</b>	<b>Intra-Service Time</b>	STS database mean skin-to-skin.
<b>4.</b>	<b>IWPUT</b>	IWPUT estimates will be collected by two surveys: (1) Paired-comparison survey with Rasch analysis to estimate relative rank order within and between families of codes; and (2) Magnitude estimation survey of codes under review relative to a reference list of RUC-reviewed codes that represent high, medium, and low IWPUTs. The CTS Expert Panel will review the results of these surveys (combined) to develop IWPUT recommendations.
<b>5a.</b>	<b>Immed. Post-time</b>	Immediate post-time (after skin closure and through discharge from recovery) will be developed by the CTS Expert Panel after reviewing the range of immediate post-service times in the RUC database for RUC-reviewed procedures. A rationale for the times developed will be provided that includes comparison to codes requiring similar physician work.
<b>5b.</b>	<b>Post -Critical Care Visits</b>	The STS database length of stay, ICU hours, and ventilator hours will be

	<b>Post - Other Hospital Visits</b>	utilized by the CTS Expert Panel to develop the post-operative hospital visit pattern ( <u>frequency and level</u> ) through discharge. A rationale for the visit levels will be provided that includes comparison to codes in the RUC database with similar LOS.
	<b>Discharge Day Visit</b>	
<b>5c.</b>	<b>Office Visits</b>	The <u>frequency and level</u> of post-discharge office visits will be developed by the CTS Expert Panel after reviewing the frequency and level of office visits in the RUC database for RUC-reviewed procedures. A rationale for the visit frequency and levels will be provided that includes comparison to codes requiring similar physician work.

Doctor Borgstede pointed out that American Society of Colon and Rectal Surgeons requested to use a mini-survey for four code families and the American Academy of Otolaryngology-Head and Neck Survey also requested using mini-surveys for six code families. Doctor Borgstede stated that the current RUC approved methodology is to allow the use of mini-surveys for low volume codes to fill in gaps within a family of codes. All other uses of the mini-surveys must be approved by the research subcommittee. The RUC accepted these two alternative methodologies without comment.

**The subcommittee recommends approving ASCRS use of a mini survey for four Proctosigmoidoscopy and Anoscopy Code Families with anchor codes 45300, 45305, 46600, and 46606.**

**The subcommittee recommends that the AAO-HNS have the option of using a full RUC surveys for base code and mini surveys for the following code families 31360, 31390, 38720, 41135, 42842, 42890.**

The Research Subcommittee recommended acceptance of an alternative methodology for two Mohs surgery codes 17304 and 17305 that would allow use of modified surveys utilizing a surgical and pathology reference service lists. Doctor Strate stated that while the Mohs codes have a pathology component, it may not be appropriate to compare that component to stand alone pathology codes. Doctor Strate explained that the physician work involved in Mohs pathology may not be typical in terms of the vignette, time, and work when compared to the pathology codes that will be used as reference codes. Therefore, Doctor Strate wanted to make sure that any data generated by through this alternative methodology is not permanently associated with the pathology codes since the pathology codes may have more work involved that the comparable Mohs pathology work. Doctor Seigel stated that this assumption may not be valid as the Mohs pathology work can be compared to pathology codes. Doctor Rich clarified that these are the issues that the workgroup will have to work out and Doctor Pfeifer stated that this was the reason for requiring the use of the standard RUC survey in addition to the modified survey. The Subcommittee recommended and the RUC approved the following recommendation:



**The subcommittee recommends that AAD can use the proposed modified survey with surgical and pathology reference service lists, but half of the potential survey respondents must be randomly selected to use the standard RUC survey and half would receive the modified survey. Additionally, 10 and 90 day global codes should not be included in the reference service list for the standard RUC survey or the modified survey.**

The North American Spine Society also presented an alternative methodology to assess changes in work over the last five to 10 years. The modified survey instrument will be used for seven codes as well as two reference services in an attempt to identify changes in work. The subcommittee recommended and the RUC approved the following:

**The specialty may use a modified RUC survey for codes 22520, 22554, 22612, 22840, 63047, 63048, and 63075, which will include surveys of time (pre, intra-service, immediate post-service), post op visits and estimates of total work. In the table surveying changes in intensity and complexity, two reference codes will be included and surveyed.**

The American College of Surgeons presented an alternative methodology utilizing data from the National Surgical Quality Improvement Program. Doctor Lichtenfeld expressed a concern that the NSQIP data may not be representative and requested that the entire database be made available for additional analysis. Doctor Borgstede clarified that that there was considerable discussion on this issue at the Research Subcommittee and it was understood that the specialty would need to demonstrate that the NSQIP data is representative, understanding that there may be problems with the presentation if the representativeness of the data can not be demonstrated.

**The Subcommittee recommended and the RUC approved the ACS proposed methodology as outlined below:**

### **ACS Proposed Alternative Five-Year Review Methodology**

<b>Presenter(s):</b>	<b>ACS Advisor</b>	
<b>Specialty(s):</b>	<b>ACS</b>	
<b>CPT Code:</b>	Per LOI	
<b>Sample Size:</b>	<b>NSQIP Database - Number of patient records utilized for review</b>	
<b>Sample Type:</b>	<b>NSQIP Database and Expert Panel</b>	
<b>1.</b>	<b>Survey RVW:</b>	Utilize the building block methodology (BBM) to calculate an RVW.
<b>2.</b>	<b>Pre- Evaluation Time</b>	Each pre-service time component will be developed by the Expert Panel after reviewing the range of pre-service times in the RUC database for RUC-reviewed procedures. A rationale for the times developed will be provided that includes comparison to codes requiring similar physician work.
	<b>Pre- Positioning Time</b>	
	<b>Pre- Scrub, Dress, Wait Time</b>	
<b>3.</b>	<b>Intra-Service Time</b>	NSQIP database MEDIAN skin-to-skin.

<b>4.</b>	<b>IWPUT</b>	IWPUT estimates will be assigned relative to a reference (anchor) code. The reference chosen will be a code that has undergone a recent full RUC survey and is a similar procedure in terms of procedure and physician work.
<b>5a.</b>	<b>Immed. Post-time</b>	Immediate post-time (after skin closure and through discharge from recovery) will be developed by the Expert Panel after reviewing the range of immediate post-service times in the RUC database for RUC-reviewed procedures. A rationale for the times developed will be provided that includes comparison to codes requiring similar physician work.
<b>5b.</b>	<b>Post -Critical Care Visits</b>	The NSQIP database length of stay will be utilized by the Expert Panel to develop the post-operative hospital visit pattern ( <u>frequency and level</u> ) through discharge. A rationale for the visit levels will be provided that includes comparison to codes in the RUC database with similar LOS.
	<b>Post - Other Hospital Visits</b>	
	<b>Discharge Day Visit</b>	
<b>5c.</b>	<b>Office Visits</b>	The <u>frequency and level</u> of post-discharge office visits will be developed by the Expert Panel after reviewing the frequency and level of office visits in the RUC database for RUC-reviewed procedures. A rationale for the visit frequency and levels will be provided that includes comparison to codes requiring similar physician work.

XV. Five-Year Review Workgroup Report (Tab L)

Doctor Richard Tuck presented the report of the Five-Year Review Workgroup on behalf of Meghan Gerety, MD. The Workgroup reviewed results of the Five-Year Review LOI Process and the assignments to the Workgroups. The Workgroup also considered a request from the American Academy of Ophthalmology (AAO) to add the eye exam codes to the Five-Year Review. The Workgroup offered that AAO may wish to solicit CMS to add the Eye Exam codes to the Five-Year Review Process. *Staff Note:* AAO has elected not to submit a request to add the eye exam codes to the Five-Year Review. Doctor Tuck also noted that Doctor Gerety had reported that AMA staff, Doctor Rich, and she met with CMS staff via conference call to address issues related to the Five-Year Review. In this call, CMS clarified that anomalies created within a family of codes when a particular individual code is refined in September will be addressed at the February 2006 RUC meeting.

*Speech Pathology/Audiology*

The American Speech-Language Hearing Association (ASHA) submitted a comment letter for the Five-Year Review. The letter includes a request for review of nearly all the speech pathology and audiology services included in CPT. For many of these services, CMS does not currently recognize physician work and the speech pathologist or audiologist time is reflected instead in the practice expense inputs. Furthermore, for many of these services, CMS does not allow the services to be independently reported by speech pathologists.

The RUC has received a request to discuss this issue. AMA staff has previously requested that CMS clarify its intents related to changing current payment policy. Several members expressed concern that the RUC should not engage in devoting large resources to review each individual code without further discussion with CMS that they are considering a change to their current payment policy for these services. Furthermore, AAO/HNS indicated that their members report the majority of these services and they do not believe that these values are incorrect.

**The RUC recommends that a letter be sent to CMS stating that the request made by ASHA in their comment letter on the Five-Year Review is not relevant to the Five-Year Review and is instead a payment policy decision to be made by CMS. If CMS chooses to change its payment policy and allow separate reporting and work valuation in these services, the RUC and/or HCPAC Review Board would review these services at that time. If CMS is able to resolve the payment policies related to this issue prior to May 17, 2005, the RUC would review the codes within this Five-Year Review process. If a payment policy change is made after May 17, 2005, the RUC and/or HCPAC Review Board would address the valuation in a separate review process.**

*Staff Note: A letter was submitted to CMS on May 5, 2005 (attached). CMS did not respond to this letter. ASHA subsequently withdrew their comments on these codes from the Five-Year Review Process.*

#### *Evaluation and Management Services*

The Five-Year Review Workgroup met to discuss the process of developing recommendations related to the Evaluation and Management services. Doctor Gerety indicated that communication and an open process will be key to successfully surveying and reviewing these services. The RUC would encourage the specialties involved to invite all the members of Workgroup 5 *Evaluation and Management Services* to attend their conference calls and/or meetings where significant decisions are to be made.

The Five-Year Review Workgroup engaged in a conversation with all meeting participants regarding the process to develop recommendations and suggested the following:

- Vignette Development - In general, a sense of collaboration has been expressed in terms of developing vignettes. It was clarified that although a common vignette is preferred in the usual RUC process, the RUC does not require that the same vignette be used by all specialties. A decision regarding the vignettes will be made by the involved specialties as they work toward consensus about the issue.

- Process of Consensus in Developing Vignettes and Reference Service List – After discussion, the Workgroup recommends that the involved specialties get together on Saturday, April 30 following the conclusion of the RUC meeting to agree to a process and timeline for consensus regarding vignettes (whether to use the same vignettes or not, consensus on the vignette is same vignette is to be used), reference service list, the survey process in general, and review of survey data and development of recommendations.

**The approved Five-Year Review Workgroup Report is attached to these minutes.**

XVI. Administrative Subcommittee Report (Tab M)

Doctor Chester Schmidt presented the Administrative Subcommittee report to the RUC. The Administrative Subcommittee met to discuss two issues including: 1.) Review of Elections Rules, Procedures and Candidates and 2.) RUC Submission Deadline Policy

Due to the election of the any other rotating seat and the internal medicine rotating seat of the RUC, Doctor Schmidt reviewed the election rules, procedures, candidates and ballots. Doctor Schmidt stated that in accordance with the election rules, the candidates for the rotating seats have all provided an abbreviated CV in tab 4 of the April RUC agenda book. The Administrative Subcommittee requested that a brief review of the Election Rules and Procedures be delivered before the RUC election.

Doctor Schmidt announced that there was a concern raised to him in regard to the lack of a formal RUC submission deadline policy. Currently, there is no policy directing AMA staff in its consideration of recommendations, comment letters or additional agenda items received after their associated deadlines. The Administrative Subcommittee discussed this issue at length and believed that a policy needed to be implemented, especially in preparation of the Five Year Review Process. The Administrative Subcommittee recommends the following language be added to the Annotated List of Actions- Procedural Issues:

**Deadlines established for materials coming to the RUC or RUC subcommittees and workgroups are to be maintained. A committee or workgroup may by a two thirds vote accept an item for discussion and action by determining that the item was of an emergent nature and could not have been placed on the agenda in accordance with the deadlines.**

XVII. Professional Liability Insurance Workgroup Report (Tab N)

Doctor Gregory Przybylski, Chair of the Professional Liability Insurance (PLI) Workgroup, presented the Workgroup report to the RUC.

As directed by the RUC at the February 2005 meeting, AMA staff reviewed the CPT codes with Medicare utilization in 2003 of fewer than 100 services reported. AMA staff indicated the dominant specialty per the 2003 Medicare utilization data, and then estimated an expected specialty for each of these 1,844 CPT codes. This spreadsheet was distributed to specialty societies on March 9. Several specialties reviewed this data and offered revisions. The PLI Workgroup incorporated all of the comments into a final spreadsheet. For approximately 13% (240 CPT codes) of these low utilization services, the recommended specialty to utilize for PLI purposes differs from the dominant specialty. An additional 152 CPT codes have zero Medicare utilization and in this case specialty is recommended. It is unknown how this determination is currently made.

**The RUC recommends that these recommendations be submitted to CMS for consideration in their 2006 rulemaking process. The RUC strongly recommends that CMS utilize these recommended specialties for low volume codes (ie, fewer than 100 claims per year), rather than rely on claims data.**

CMS has stated that the agency does not agree with the RUC recommendation to use the dominant specialty approach in the PLI relative value methodology. However, CMS is interested in exploring a threshold analysis technique which would remove specialties from the calculation of PLI relative values for an individual CPT code when the specialty performs less than a certain percentage of the overall utilization (1%, 3%, or 5%).

**The RUC recommends that the dominant approach should continue to be reiterated as a recommendation to CMS. The RUC recommends the dominant approach as the preferable method to select the risk factor to assign to each CPT code. However, in responding to the CMS request to review the various threshold levels, the RUC should recommend the 5% level to CMS as it most closely reflects the dominant approach. The RUC considers the recommendation to implement a threshold as an interim step and will continue to advocate the dominant approach.**

The American Society for Surgery of the Hand (ASSH) requested that the RUC submit a recommendation to CMS that the PLI premium data for hand surgery of \$28,974 (determined utilizing rating manuals from five insurers) is not appropriate. The ASSH noted that 70% of their members are orthopaedic

surgeons and their premium data would be reflective of orthopaedic surgery without spine. The PLI Workgroup agreed and supports a RUC recommendation to CMS.

**The RUC recommends that a letter be submitted to CMS advocating a change in the PLI risk factor for hand surgery. Hand surgery should be crosswalked to orthopaedic surgery (without spine). The RUC requested that ASSH provide additional support (ie, a letter) that indeed most hand surgeons are orthopaedic surgeons and incur the same PLI premiums as orthopaedic surgeons.**

**The approved PLI Workgroup Report and the letter to CMS are attached to these minutes.**

#### XVIII. Practice Expense Subcommittee

The Practice Expense Subcommittee conducted its business via email prior to the April 2005 RUC meeting regarding physician time allocations for four codes that were reviewed for practice expenses at the February 2005 RUC/PERC meeting. These codes were refined by PERC without physician intra-service time being used as a benchmark, which is typically done during PERC discussions.

The subcommittee considered four time submissions from two different specialties. All time allocations accepted by the RUC are shown in the full minutes of the Practice Expense Subcommittee report. **The RUC approved Practice Expense Subcommittee recommendations, and the full report is attached to these minutes.**

XIX. Other Issues

A RUC member noted that there is now a question on the survey that whether the procedure is predominately performed with conscious sedation. There will be some mechanism to identify codes that are not currently on the conscious sedation list in CPT but are inherently billed in conjunction with specific procedures. Such codes will then be added to the conscious sedation list.

Doctor Rich thanked the pre-facilitation and facilitation committee members and chairs. Doctor Rich also thanked the specialty society staff and AMA staff.

Doctor Rich clarified that the E/M Five-Year Review workgroup must abide by the outlined timeline. Any vignette review must be sent to AMA staff and will be sent out to the workgroup for review.

A RUC member questioned if information posted on specialty society websites mentioning the financial impact of E/M code revisions should be taken down immediately so it does not influence survey results. Doctor Rich indicated that any communication or introductory letters should be cleared through the appropriate Five-Year Review workgroup before posted or sent out to surveyees.

**The meeting adjourned on Sunday, May 1, 2005 at 10:00 am.**

**AMA/Specialty Society RVS Update Committee  
Practice Expense Review Committee (PERC)  
April 27 – May 1, 2005  
Chicago, IL**

Bill Moran, MD (Chair)  
James Anthony, MD  
Joel V. Brill, MD  
Neal H. Cohen, MD  
Thomas A. Felger, MD  
Katherine Bradley, PhD, RN

Gregory Kwasny, MD  
Peter McCreight, MD  
Tye Ouzounian, MD  
James B. Regan, MD  
Anthony Senagore, MD  
Richard A. Dickey, MD

**Call to Order**

Doctor Moran called the group to order and explained to the members that the purpose of the committee is to critically review practice expense (PE) recommendations prior to the specialties' full code presentation to the RUC. In addition, during the code discussion at the RUC, the RUC chair will begin the code discussion by asking Doctor Moran if the PE inputs reflect the PERC consensus. If Doctor Moran indicates the PE recommendations do not reflect the PERC's recommendations and a line by line review is needed, the RUC will decide whether the code will go directly to facilitation without discussion on work.

**CMS Update**

Ken Simon, MD from CMS provided the following CMS update to the group:

- CMS is currently working on the proposed rule due out in June
- Pay for performance initiatives are continuing as CMS's administrator is committed to its implementation to incentives for high quality physician services.
- CMS is looking forward the RUC's Five Year Review this summer.

**Special Requests**

**95071 and 97075**

The PERC reviewed two special requests concerning existing codes. The first special request came from the Joint Council of Allergy, Asthma, and Immunology (JCAAI). The PERC reviewed codes 95071 and 95075 at the February 2005 PERC meeting in Tucson. JCAAI requested the codes to be reconsidered at this meeting. JCAAI believed that their organization was not fairly represented because their representative could not attend during the PERC's review of the codes.

During the discussion of codes 95071 and 95075, JCAAI withdrew its interest in revisiting code 95071. The PERC and the JCAAI representative discussed in detail the clinical labor activities of code 95075 and came to the conclusion that the PERC's recommendation from February 2005 was an accurate description of the practice expense inputs and agreed not to make another recommendation for the code.

**93012, 93268, 93270, and 93271**

The CMS, and ACC requested, on behalf of a coalition of independent diagnostic testing facilities (IDTF), a reviewed of the practice expenses for four Cardiac Event Monitoring codes. The codes were reviewed by the PEAC in March 2004 with the assistance of ACC, however



the data available at the time may not have been sufficient to warrant a clear description of the direct inputs involved.

Upon request of CMS and ACC, the PERC again reviewed codes 93012, 93268, 93270, and 93271 with the assistance of representatives from a coalition of IDTFs who had been invited as guests of the ACC to answer questions that might arise. Based on new data provided through CMS by the coalition, the PERC recommended the attached revised direct inputs for codes 93012 and 93271 only as these codes were understood to pertain to IDTFs and not to physicians. The revision by the PERC represents an increase of 41 and 71 minutes of clinical labor time for codes 93012 and 93271 respectively, and some additional supplies and equipment (see attached spreadsheets). Codes 93268 is billed by physicians, and not solely in IDTFs from which the new data had been collected, it was decided by the PEAC to hold that code to the original recommendation from the PEAC in March 2004. In addition, code 93270 was not changed from its original March 2004 PEAC recommendation, but reviewed by the committee.

Although the PERC made this recommendation, some members believed that it had been inappropriate for a non-MD consultant and an industry representative, without specialty society endorsement, to present at the PERC (and this statement was requested to be reflected in the minutes). It was clarified at the meeting that both CMS and ACC requested the attendance of both individuals. ACC staff and representatives from CMS stated they were not endorsing the recommendation, but wanted representatives from the IDTFs to have the opportunity to discuss the codes that only pertain to them.

#### **Committee Discussion of Process**

During the meeting PERC members discussed their perceptions of their work efforts upon the RUC deliberations. In addition, PERC members believed that there had not been enough time allocated to the discussion of practice expense during facilitation committee meetings at recent RUC meetings. Doctor Rich mentioned that he appreciates the PERC's review of the PE recommendations and reiterated that the PERC will be reviewing each recommendation in detail in order to provide feedback to the presenting specialty society and the RUC.

#### **Practice Expense Review Committee (PERC)**

In addition, PERC members believed that under the current PERC process, when there is a presenting physician present all practice expense issues are quickly and completely resolved. However, when a physician presenter is not present, the PE issues are not easily resolved. The PERC would like to emphasize to the RUC that a presenting physician from the society is extremely helpful to the entire PERC process (and requested that this statement be reflected in the minutes).

#### **New and Revised Codes Reviewed**

The PERC reviewed all the practice expense input recommendations in the following RUC tabs:

Tab 6 Free Skin Grafts (15000 – 1543X – 45 codes)
Tab 15 Mechanical Thrombectomy (37XX1 – 37XX5)
Tab 20 Ureteral Stent Exchange/Removal (503X2 – 503X6)
Tab 21 Percutaneous Radiofrequency Ablation of Renal Tumors (505XX)
Tab 23 Endometrial Sampling (574X1)

Tab 25 Hyperhidrosis Chemodenervation (6468X1 – 6468X4)
Tab 26 Blepharoptosis Repair, Harvest Fascia (67901 – 67902)
Tab 27 3D Imaging Rendering (763XX1-763XX2)
Tab 28 Stereoscopic X-Ray Guidance (774XXX)
Tab 29 Intraoperative Consult and Touch Prep (8833X1-8833X2)
Tab 30 Multiple Molecular Marker Array-Based Evaluation (883X1-883X3)
Tab 31 Needle EMG with Chemodenervation (95858X-95859X: 64612-64614)
Tab A Complex EMG (95867-95868;9586X-9586X1)
Tab B Education and Training for Patient Self Management (99XX2, 99XX3)
Tab E Nursing Facility Services (9930X1-992X2)
Tab F Domiciliary Care Services (993X1 – 993X9)

**AMA/Specialty Society RVS Update Committee  
RUC HCPAC Review Board Meeting  
April 27, 2005**

Members Present:

Richard Whitten, MD, Chair  
Mary Foto, OTR, Co-Chair  
Jonathan Cooperman, PT  
Robert Fifer, PhD  
James Georgoulakis, PhD  
Anthony Hamm, DC  
Emily H. Hill, PA-C

Bernard Pfeifer, MD  
Christopher Quinn, OD  
Lloyd Smith, DPM  
Doris Tomer, LCSW  
Arthur Traugott, MD  
Jane White, PhD, RD, FADA

**I. CMS Update**

Edith Hambrick, MD, provided a CMS update and informed the HCPAC that CMS will issue a proposed rule this summer, and comments should be sent to CMS 60 days after the *Proposed Rule* is issued. Doctor Hambrick also responded to HCPAC questions regarding the non-physician work pool, CMS continues to study a resolution to the non-physician work pool issue.

**II. Administrative Issues**

The HCPAC voted to elect the RUC HCPAC Co-Chair and Alternate Co-Chair. Mary Foto, OTR, was re-elected to remain the HCPAC Co-Chair for a second two-year term. Robert Fifer, PhD, was also re-elected to remain the HCPAC Alternate Co-Chair for a second two-year term.

**III. PLI Discussion**

CMS indicated in the November 15 *Final Rule* that the agency was interested in RUC input on the appropriateness of the PLI crosswalk assumptions. The risk factors are currently set at the all physician risk factor for the professions indicated below. The RUC requested the PLI risk factor be set to 1.00 (\$6,100) for the following eight health professionals. The RUC also invited these professions to present evidence that their annual PLI premiums are greater than \$6,100. These professions include:

- Clinical Psychologist
- Licensed Clinical Social Worker
- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

The National Association of Social Workers (NASW) have submitted PLI premium data indicating that it is approximately \$500, which is well under \$6,100. Doctor Whitten, HCPAC Chair, indicated that data from the HCPAC that is specific and accurate to address

this issue, would be beneficial. CMS indicated that the agency would welcome and review any PLI premium estimates that the HCPAC would submit. **The HCPAC professions indicated will make best effort to gather information on the collection of PLI premium data and submit it to RUC HCPAC staff by September 1, 2005 to be discussed at the September 2005 RUC HCPAC meeting.**

#### **IV. Update on Gait and Motion Analysis (96000-96003)**

In April 2001, the RUC HCPAC Review Board reviewed the gait and motion analysis codes 96000-96003, brought forth by the American Physical Therapy Association (APTA). The HCPAC concluded that the vignettes needed to be clarified for the services provided prior to conducting a survey. In January 2002, the HCPAC reviewed the surveyed gait and motion analysis codes. However, due to a flaw in the survey process the validity and accuracy of these codes were questioned. The HCPAC, recommended maintaining the current values assigned by CMS until more accurate survey data could be obtained. The APTA added that they would consult the Clinical Gait and Movement Analysis Society for further information regarding the time data. The Clinical Gait and Movement Analysis Society were contacted and flawed survey data was received.

At today's meeting, Jim Nugent from APTA indicated that no action on the work values will be made at this time. APTA will be examining description and work involved in the facility and non-facility settings and will bring codes 96001-96003 to CPT in approximately two years. **The HCPAC recommends that 96000, 96001, 96002 and 96003 be identified as under CPT Review in the database.**

#### **V. Five-Year Review Issues**

Two codes will be coming to the HCPAC in the September 2005 Five-Year Review: 11730 *Removal of nail plate* and 29580 *Application of paste boot*. The American Speech-Language-Hearing Association has also submitted a comment pertaining to all audiology and speech pathology codes. *Staff Note: The Five-Year Review Workgroup has recommended that a letter be sent to CMS requesting that CMS clarify the payment policies related to this issue by May 15 or this issue may not be able to be addressed in this Five-Year Review.*

#### **VI. Relative Value Recommendations for CPT 2006**

*Auditory Rehabilitation Assessment (92506, 926X1, 926X2, 926X3, 92507, 926X4, 92508)*

##### 92506, 92507 and 92508

Robert Fifer, PhD, CCC-A and Nancy Swigert, MA, CCC-SLP, presented the American Speech-Language-Hearing Association (ASHA) recommendations for the auditory rehabilitation assessment codes. The HCPAC discussed codes 92506 *Evaluation of speech, language, voice, communication, and/or auditory processing* (Work RVU=0.86), 92507 *Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual* (Work RVU=0.52) and 92508 *group, two or more individuals* (Work

RVU=0.26) and determined that the changes were editorial. **The HCPAC recommends that the current work values be maintained.**

926X1, 926X2, 926X3 and 926X4

Dr. Fifer presented the practice expense for codes 926X1 *Evaluation of auditory rehabilitation status; first hour*, 926X2 *each additional 15 minutes (List separately in addition to code for primary procedure)*, 926X3 *Auditory rehabilitation, pre-lingual hearing loss*, and 926X4

*Auditory rehabilitation, post-lingual hearing loss.* **For guidelines on defining time for 926X1 and 926X2 the HCPAC requests that CPT add the following parenthetical: (When reporting 926X1,926X2 use the face-to-face time with the patient or family). Addition of the parenthetical is contingent upon CPT acceptance.** After discussion, the HCPAC amended the practice expense to reflect PEAC standards.

*Psychological Testing Exam (9610X, 9610X1, 9610X2)*

James Georgoulakis, PhD, Antonio Puente, PhD, and additional American Psychological Association (APA) representatives presented APA’s recommendations for the psychological testing exam codes. The HCPAC examined the CPT descriptors for the psychological testing exam codes and determined that clarification was needed to specify the psychologist’s or physician’s time as well as face-to-face time. **The HCPAC requests that CPT amend code descriptors for 9610X, 9610X1 and 9610X2 as indicated in the table below. This descriptor change is contingent upon CPT acceptance.**

Code	Descriptor
9610X	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS); <del>administered face to face with the patient, interpreted, and reported by a qualified health care professional, per hour; per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time preparing the report.</del>
9610X1	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS); <del>administered by a technician, face to face with the patient, with qualified health care professional interpretation and report, per hour</del> <u>per one hour of technician-administered time.</u>
9610X2	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI); <del>administered by a computer, with qualified health care professional interpretation and report, per hour</del> <u>administered by a computer, with report.</u>

The HCPAC valued codes 9610X, 9610X1 and 9610X2 based on the amended descriptors. After extensive examination, the HCPAC crosswalked code 9610X to code 90806 *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;* (Work RVU=1.86) to establish a comparable work RVU for code 9610X. The HCPAC also amended the pre-, intra- and post-service time for code 9610X (pre-service time = 7 minutes, intra-service time = 60 minutes and post-service time = zero minutes).

The HCPAC crosswalked code 9610X1 to 96150 *Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment* (Work RVU=0.50) for the pre-service, intra-service and post-service times. APA also crosswalked 9610X to 90806 to establish a comparable work RVU for code 9610X.

Additionally, the HCPAC crosswalked 9610X2 to codes 93014 *Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; physician review with interpretation and report only* (Work RVU=0.52, pre =

10 minutes, intra = 20 minutes and post = 12 minutes) and 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (Work RVU=0.17 pre = zero minutes, intra = 5 minutes and post = zero minutes) to develop service times and the work RVU.

**The HCPAC recommends the service times for codes 9610X, 9610X1 and 9610X2 as indicated in the table below. The HCPAC recommends 1.86 Work RVU for code 9610X, 0.50 Work RVU for code 9610X1 and 0.51 for code 9610X2.**

Code	Pre-Service	Intra-Service	Post-Service	Work RVU	Reference Code
9610X	7	60	0	1.86	90806
9610X1	3	15	5	0.50	96150
9610X2	8	8	14	0.51	93000 and 93014

Practice Expense

After extensive discussion, **the HCPAC amended the practice expense to reflect PEAC standards.**

*Neurobehavioral Status Exam (9611X, 9611X1, 9611X2, 9611X3)*

Dr. Georgoulakis and Dr. Puente presented the neurobehavioral status exam codes. The HCPAC examined the CPT descriptors for the neurobehavioral status exam codes and determined that clarification was needed to specify the psychologist’s or physician’s time as well as face-to-face time. **The HCPAC requests that CPT amend code descriptors for 9611X1, 9611X2 and 9611X3 as indicated in the table below. This descriptor change is contingent upon CPT acceptance.**

Code	Descriptor
9611X	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities); <del>administered face to face with the patient, interpreted, and reported by a qualified health care professional, per hour</del> <u>per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time preparing the report.</u>
9611X1	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); <del>administered face to face with the</del>

	<del>patient, interpreted, and reported by a qualified health care professional, per hour per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.</del>
9611X2	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); <del>administered by technician, face to-face with the patient, with qualified health care professional interpretation and report, per hour</del> <u>per one hour of technician-administered time.</u>
9611X3	Neuropsychological testing (eg, Wisconsin Card Sorting Test); <del>administered by a computer, with qualified health care professional interpretation and report, per hour</del> <u>administered by a computer, with report.</u>

The HCPAC valued codes 9611X-9611X3 based on the amended descriptors. After examination, the HCPAC used the same methodology as associated with codes 9610X-9610X2 when developing the service times and work RVUs. The HCPAC agreed that a 10% increase in the IWPUT from codes 9610X-9610X1 would appropriately reflect an increase the Work RVUs for codes 9611X-9611X2 due to the increased mental effort, technical skill and physical effort associated with these codes. The Work RVU for 9611X3 was directly crosswalked from 9610X2. Additionally, the pre-, intra- and post- service times for 9611X-9611X3 were crosswalked from 9610X-9610X2.

**The HCPAC recommends the service times for codes 9611X, 9611X1, 9611X2 and 9611X3 as indicated in the table below. The HCPAC recommends 2.05 work RVU for code 9611X, 2.05 for code 9611X1, 0.55 for code 9611X2 and 0.51 for code 9611X3.**

Code	Pre-Service	Intra-Service	Post-Service	Work RVU	Crosswalk
9611X	7	60	0	2.05	9610X
9611X1	7	60	0	2.05	9610X
9611X2	3	15	5	0.55	9610X1
9611X3	8	8	14	0.51	9610X2

Practice Expense

After extensive discussion, **the HCPAC amended the practice expense to reflect PEAC standards.**

**VII. Other Issues**

AMA staff included background material to educate the HCPAC on the evolution and status of the non-physician work pool.

### **Research Subcommittee Report**

April 27, 2005 1:00 pm – 2:30 pm

April 29, 2005 8:00 am -- 9:00 am

The Research Subcommittee met to review proposed Alternative Methodologies for the Five-Year Review. The following Subcommittee members participated in the meetings: Doctors Trexler Topping (chair, April 27), James Borgstede, (chair, April 29) James Blankenship (April 29), Norman Cohen, John Gage, Meghan Gerety, Barbara Levy, Doug Leahy (alt) Brenda Lewis (alt, April 29), Bernard Pfeifer, Alan Plummer, Richard Tuck, and Katherine Bradley, RN, PhD.

### **American Society of Colon and Rectal Surgeons (ASCRS)**

The ASCRS has proposed reviewing physician work relative value units for the proctosigmoidoscopy and anoscopy families of codes during the current 5-year review process. Because these 20 codes: (1) Vary in typical site-of-service locations (FAC versus NF); (2) Include codes that are infrequently performed; and (3) Have RVWs that are within a tight RVW range, the ASCRS is proposing to conduct four full RUC surveys for codes 45300, 45305, 46600, and 46606, and mini-surveys for the remaining codes. The RUC reviewed the request and concluded that the ASCRS request is consistent with the following recommendation that has already been approved by the RUC:

Proposed at the April 27, 2000 Research Meeting and approved at the April 27-30, 2000 RUC meeting: The use of a minisurvey should be restricted for low volume codes to fill in gaps within a family of codes.

The ASCRS proposed mini-survey format will include pre, and intra time estimates as well as a recommended RVU and the survey format is attached to the subcommittee report.

**The subcommittee recommends approving ASCRS use of a mini survey for four Proctosigmoidoscopy and Anoscopy Code Families with anchor codes 45300, 45305, 46600, and 46606.**

### **American Academy of Dermatology**

American Academy of Dermatology and the American College of Mohs Micrographic Surgery and Cutaneous Oncology requested approval of a modified RUC survey to survey the Mohs codes, 17304 and 17305. The proposal was to use two Reference Service Lists, one for the surgical part of the procedure, and another for the pathological component. The presenters explained that since the Mohs codes contained a surgical and pathology components, both reference services would be used to construct a Mohs code value. The subcommittee had significant concerns with this approach since it would potentially lead to double counting of physician work. Specifically, the subcommittee felt that pre-service and post-service work would be double counted. The subcommittee discussed a variety of ways to improve the survey to alleviate the subcommittee's concerns of double counting work. Several subcommittee members were not convinced that the Mohs codes were unique in that it contained part surgery and part pathology since there are other surgical codes that contain surgical and radiology components and those procedures are evaluated using the standard RUC survey.



The Subcommittee was also concerned that the reference service list contained 10 and 90 day global period codes. The AAD presenter recommended using these global period codes, remove the E/M code values from the codes but the subcommittee felt that this approach was problematic and that using reference codes with zero day global periods was appropriate.

The Subcommittee did not recommend approving the AAD proposed survey to be used as a substitute for the standard RUC survey. However, it was suggested that the proposed modified survey could be used in conjunction with the standard RUC survey and the results from the two surveys could be compared. The subcommittee stressed that 10 and 90 day global period codes should not be on the reference service list and the specialty was encouraged to share its reference service list to the appropriate five-year review workgroup for comment because the AAD was concerned that the 000 day codes would not allow appropriate comparisons with the Mohs codes.

**The subcommittee recommends that AAD can use the proposed modified survey with surgical and pathology reference service lists, but half of the potential survey respondents must be randomly selected to use the standard RUC survey and half would receive the modified survey. Additionally, 10 and 90 day global codes should not be included in the reference service list for the standard RUC survey or the modified survey.**

#### **American Academy of Head and Neck Surgery (AAO-HNS)**

The American Head and Neck Society (AHNS) and the American Academy of Otolaryngology Head & Neck Surgery requested approval of a methodology that would allow for a full RUC survey of several base codes and then use an expert panel to maintain rank order among the other codes in the base code family. The intent of this methodology would be to survey base codes and then apply the results of the base code change to the other codes in the family. The research subcommittee was concerned that applying the same change to the codes in the family may overestimate the post-service work. Also without new time data for the codes, the end result could be an underestimate of PE RVUs. The research subcommittee also noted that the proposal lacked sufficient detail and therefore the Research subcommittee did not approve the AAO-HNS request. The subcommittee did suggest that the specialty could use, but is not required to use full RUC surveys for the base code and mini surveys for the other codes in each family.

**The subcommittee recommends that the AAO-HNS have the option of using a full RUC surveys for base code and mini surveys for the following code families 31360, 31390, 38720, 41135, 42842, 42890.**

#### **North American Spine Surgery**

The North American Spine Society (NASS) requested to use a modified and shortened RUC survey for seven codes in an attempt to increase the response rate. Because these are high volume codes and because these codes are linked to many other spine surgery codes, NASS wanted to survey a large number of surgeons and felt that the existing RUC survey would not result in a high response rate. NASS proposed a modified version of the standard RUC survey that will gather traditional RUC time data for the pre, intra, and post service periods for each of the seven codes. For intensity and complexity, however, NASS will collect data on the changes that have occurred during the past 5-10 years in the performance of these procedures rather than the absolute numbers collected by the standard RUC survey. The Research Subcommittee had a number of concerns

with this approach due to the lack of comparison with reference codes. The Subcommittee modified the proposed methodology so that reference codes are incorporated in the methodology. The Research Subcommittee suggested that the specialty utilize a the modified survey but the survey should include two reference services that will be surveyed so the data can be compared to reference services. In addition the survey would include the intensity questions from the RUC survey but the survey respondents will be asked to indicate the changes if any during the past 5-10 years in the complexity and intensity for each component. The research subcommittee recommends approval of the following alternative methodology for NASS :

**The specialty may use a modified RUC survey for codes 22520, 22554, 22612, 22840, 63047, 63048, and 63075, that will include surveys of time (pre, intra-service, immediate post-service), post op visits and estimates of total work. In the table surveying changes in intensity and complexity, two reference codes will be included and surveyed.**

### **American College of Surgeons**

Doctor Mabry presented a detailed presentation on a proposed alternative methodology that would utilize data developed from the National Surgical Quality Improvement Program (NSQIP). The NSQIP was started by the VA for quality improvement purposes but now includes a large volume of surgical procedures from non-VA hospitals as well. The NSQIP database contains intra-service times and length of stay data. The ACS proposed a building block methodology that would use a consensus panel to assign pre service times, immediate post service times as well as IWPUT estimates. The intra-service times would be the median times from the NSQIP database. The NSQIP database length of stay will be used by the expert panel to develop number and level of hospital visits. The expert panel will also develop number and level of office visits based on comparisons to codes requiring similar physician work. The ACS is proposing using this methodology for 21 codes currently scheduled for the five-year review.

The Subcommittee members asked a number of questions pertaining whether the data is skewed. For example, some members were concerned that the NSQIP only contained teaching hospitals that may have length of stay data that may not represent typical patients. It was felt that the data may be skewed toward VA and teaching hospital data. It was suggested, if possible, that ACS identify other datasets to use as a means of validating the NSQIP data. Other members were concerned that this methodology would not involve RUC surveys and would be heavily dependent on IWPUT and expert panel input. Additionally, since some of the codes are performed in ASCs, the NSQIP would not reflect these settings and therefore the database might overestimate length of stay data since those performed in an ASC would not have a length of stay.

It was suggested that the ACS will need to demonstrate that the data from NSQIP is not biased by providing distribution data to show whether or not the data is skewed. Such as median and standard deviations. It will be the responsibility of the ACS to convince the workgroup that the data is not skewed by providing distribution data such as standard deviations. Given the additional statistical data that will be provided to the workgroup, the Subcommittee was comfortable with the proposed methodology.

The research subcommittee recommends acceptance of the ACS proposed methodology as outlined below:

### ACS Proposed Alternative Five-Year Review Methodology

<b>Presenter(s):</b>	ACS Advisor	
<b>Specialty(s):</b>	ACS	
<b>CPT Code:</b>	Per LOI	
<b>Sample Size:</b>	NSQIP Database - Number of patient records utilized for review	
<b>Sample Type:</b>	NSQIP Database and Expert Panel	
<b>1.</b>	<b>Survey RVW:</b>	Utilize the building block methodology (BBM) to calculate an RVW.
<b>2.</b>	<b>Pre- Evaluation Time</b>	Each pre-service time component will be developed by the Expert Panel after reviewing the range of pre-service times in the RUC database for RUC-reviewed procedures. A rationale for the times developed will be provided that includes comparison to codes requiring similar physician work.
	<b>Pre- Positioning Time</b>	
	<b>Pre- Scrub, Dress, Wait Time</b>	
<b>3.</b>	<b>Intra-Service Time</b>	NSQIP database MEDIAN skin-to-skin.
<b>4.</b>	<b>IWPUT</b>	IWPUT estimates will be assigned relative to a reference (anchor) code. The reference chosen will be a code that has undergone a recent full RUC survey and is a similar procedure in terms of procedure and physician work.
<b>5a.</b>	<b>Immed. Post-time</b>	Immediate post-time (after skin closure and through discharge from recovery) will be developed by the Expert Panel after reviewing the range of immediate post-service times in the RUC database for RUC-reviewed procedures. A rationale for the times developed will be provided that includes comparison to codes requiring similar physician work.
<b>5b.</b>	<b>Post -Critical Care Visits</b>	The NSQIP database length of stay will be utilized by the Expert Panel to develop the post-operative hospital visit pattern ( <u>frequency and level</u> ) through discharge. A rationale for the visit levels will be provided that includes comparison to codes in the RUC database with similar LOS.
	<b>Post - Other Hospital Visits</b>	
	<b>Discharge Day Visit</b>	
<b>5c.</b>	<b>Office Visits</b>	The <u>frequency and level</u> of post-discharge office visits will be developed by the Expert Panel after reviewing the frequency and level of office visits in the RUC database for RUC-reviewed procedures. A rationale for the visit frequency and levels will be provided that includes comparison to codes requiring similar physician work.

**ASCRS format for mini-table to be added to a full RUC survey for an anchor code.**

	<b>45305</b>	45303	45307	45308	45309	45315	45320	45321	45327
	<b>Proctosigmoidoscopy, rigid; with biopsy, single or multiple</b>	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)	Proctosigmoidoscopy, rigid; with removal of foreign body	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	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)	Proctosigmoidoscopy, rigid; with decompression of volvulus	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)
<b>Pre-service evaluation:</b>	AUTO FILLED FROM FULL RUC SURVEY								
<b>Pre-service positioning:</b>									
<b>Pre-service scrub, dress, wait:</b>									
<b>Intra-service (skin-to-skin):</b>									
<b>Post-service time</b>									
<b>RVW Estimate</b>									
<b>Experience past 12 months</b>									

**AMA/Specialty Society RVS Update Committee  
Five-Year Review Workgroup  
April 27, 2005**

The Five-Year Review Workgroup met on Wednesday, April 27, 2005 and Saturday, April 30, 2005 to discuss the various procedural issues related to the Five-Year Review of the RBRVS. The following Workgroup members participated: Doctors Meghan Gerety (Chair), John Gage, David Hitzeman, Charles Koopmann, Doug Leahy, MD, Trexler Topping, Arthur Traugott, Richard Tuck, Robert Zwolak, and Emily Hill, PA-C.

Results of the Five-Year Review LOI Process/Assignments to Workgroups

The Five-Year Review Workgroup reviewed the workgroup composition and code assignments and did not suggest any revision. The final documents will be distributed to all RUC participants with the survey documents by May 9, 2005.

Evaluation and Management Services

The American Academy of Ophthalmology (AAO) submitted a March 31, 2005 letter to the Five-Year Review Workgroup requesting action related to the Eye Exam codes. AAO provided documentation that in the 1995 Five-Year Review process, the RUC recommended that a “permanent link” be established between the Eye Exam codes and the Office Visit codes. The Workgroup noted that it is not possible to automatically determine at this point in time that any rationale in the Office Visit codes would automatically apply to the Eye Exam codes. The Workgroup offered that AAO may wish to solicit CMS to add the Eye Exam codes to the Five-Year Review Process. If CMS agrees to this request, these codes would be included in a Level of Interest process and then assigned to Workgroup 5 *Evaluation and Management Services* to review survey data presented by the specialty.

Speech Pathology/Audiology Services

The American Speech-Language Hearing Association (ASHA) submitted a comment letter for the Five-Year Review. The letter includes a request for review of nearly all the speech pathology and audiology services included in CPT. For many of these services, CMS does not currently recognize physician work and the speech pathologist or audiologist time is reflected instead in the practice expense inputs. Furthermore, for many of these services, CMS does not allow the services to be independently reported by speech pathologists.

The RUC has received a request to discuss this issue. AMA staff have previously requested that CMS clarify its intents related to changing current payment policy. Several members expressed concern that the RUC should not engage in devoting large resources to review each individual code without further discussion with CMS that they are considering a change to their current payment policy for these services. Furthermore, AAO/HNS indicated that their members report the majority of these services and they do not believe that these values are incorrect.

**The Workgroup recommends that a letter be sent to CMS stating that the request made by ASHA in their comment letter on the Five-Year Review is not relevant to the Five-Year Review and is instead a payment policy decision to be made by CMS. If CMS chooses to change its payment policy and allow separate reporting and work valuation in these services, the RUC and/or HCPAC Review Board would review these services at that time. If CMS is able to resolve the payment policies related to this issue prior to May 17, 2005, the RUC would review the codes within this Five-Year Review process. If a payment policy change is made after May 17, 2005, the RUC and/or HCPAC Review Board would address the valuation in a separate review process.**

#### Evaluation and Management Services

The Five-Year Review Workgroup met to discuss the process of developing recommendations related to the Evaluation and Management services. Doctor Gerety indicated that communication and an open process will be key to successfully surveying and reviewing these services. The RUC would encourage the specialties involved to invite all the members of Workgroup 5 *Evaluation and Management Services* to attend their conference calls and/or meetings where significant decisions are to be made.

The Five-Year Review Workgroup engaged in a conversation with all meeting participants regarding the process to develop recommendations and suggested the following:

- Vignette Development - In general, a sense of collaboration has been expressed in terms of developing vignettes. It was clarified that although a common vignette is preferred in the usual RUC process, the RUC does not require that the same vignette be used by all specialties. A decision regarding the vignettes will be made by the involved specialties as they work toward consensus about the issue.
- Process of Consensus in Developing Vignettes and Reference Service List – After discussion, the Workgroup recommends that the involved specialties get together on Saturday, April 30 following the conclusion of the RUC meeting to agree to a process and timeline for consensus regarding vignettes (whether to use the same vignettes or not, consensus on the vignette is same vignette is to be used), reference service list, the survey process in general, and review of survey data and development of recommendations.

#### Other Issues

- Doctor Gerety reported that AMA staff, Doctor Rich, and she met with CMS staff via conference call to address issues related to the Five-Year Review. In this call, CMS clarified that anomalies created within a family of codes when a particular individual code is refined in September will be addressed at the February 2006 RUC meeting.

**AMA/Specialty Society RVS Update Committee  
Administrative Subcommittee Report  
April 29, 2005**

Members Present: Doctors Chester Schmidt, Jr., Chair, Sherry Barron-Seabrook, Dennis Beck, Peter A. Hollmann, Charles Mick, J. Baldwin Smith, III, Richard Whitten and Robert Fifer, PhD

*Review of Election Rules, Procedures and Candidates*

Due to the election of the any other rotating seat and the internal medicine rotating seat of the RUC, Doctor Schmidt reviewed the election rules, procedures, candidates and ballots. Doctor Schmidt stated that in accordance with the election rules, the candidates for the rotating seats have all provided an abbreviated CV in tab 4 of the April RUC agenda book. The Administrative Subcommittee requested that a brief review of the Election Rules and Procedures be delivered before the RUC election.

*RUC Submission Deadline Policy*

Doctor Schmidt announced that there was a concern raised to him in regard to the lack of a formal RUC submission deadline policy. Currently, there is no policy directing AMA staff in its consideration of recommendations, comment letters or additional agenda items received after their associated deadlines. The Administrative Subcommittee discussed this issue at length and believed that a policy needed to be implemented, especially in preparation of the Five Year Review Process. The Administrative Subcommittee recommends the following language be added to the Annotated List of Actions- Procedural Issues:

**Deadlines established for materials coming to the RUC or RUC subcommittees and workgroups are to be maintained. A committee or workgroup may by a two thirds vote accept an item for discussion and action by determining that the item was of an emergent nature and could not have been placed on the agenda in accordance with the deadlines.**

**AMA/Specialty Society RVS Update Committee  
Professional Liability Insurance Workgroup  
April 29, 2005**

The following members of the Professional Liability Insurance (PLI) Workgroup met on April 29, 2005 to discuss numerous issues related to the CMS methodology to compute PLI relative values. Doctors Gregory Przybylski (Chair), Neil Brooks, Norman Cohen, David Hitzeman, Stephen Kamenetzky, Sandra Reed, J. Baldwin Smith, and Mary Foto, OTR.

Dominant Specialty Approach/Review Aberrant Data Patterns in Low-Utilization Services

As directed by the RUC at the February 2005 meeting, AMA staff reviewed the CPT codes with Medicare utilization in 2003 of fewer than 100 services reported. AMA staff indicated the dominant specialty per the 2003 Medicare utilization data, and then estimated an expected specialty for each of these 1,844 CPT codes. This spreadsheet was distributed to specialty societies on March 9. Several specialties reviewed this data and offered revisions. AMA staff and the PLI Workgroup incorporated all of the comments from the following specialty societies (specific comments are included on the RUC meeting CD):

American Academy of Dermatology  
American Academy of Family Physicians  
American Academy of Neurology  
American College of Cardiology  
American College of Emergency Physicians  
American College of Obstetricians and Gynecologists  
American College of Chest Physicians  
American College of Surgeons  
American Society of Colon and Rectal Surgeons  
American Society of Plastic Surgeons  
American Society for Surgery of the Hand  
American Thoracic Society  
American Urological Association  
Infectious Diseases Society of America  
Society of Thoracic Surgeons  
The Endocrine Society

For approximately 13% (240 CPT codes) of these low utilization services, the recommended specialty to utilize for PLI purposes differs from the dominant specialty. An additional 152 CPT codes have zero Medicare utilization and in this case specialty is recommended. We do not know how this determination is currently made. The PLI Workgroup reviewed the revised spreadsheet included in the RUC agenda book (Tab N) and made the following modifications:



- CPT codes 37615, 43101, 43108, and 43118 will be modified to list General Surgery as the dominant specialty.
- CPT code 21610 will be modified to list Neurosurgery as the dominant specialty.
- CPT codes 33470, 33472, 33665, and 33764 will be modified to list Cardiac Surgery as the dominant specialty.

**The PLI Workgroup recommends that the RUC forward these recommendations to CMS for consideration in their 2006 rulemaking process. The RUC should strongly recommend that CMS utilize these recommended specialties for low volume codes (ie, fewer than 100 claims per year), rather than rely on claims data.**

#### CMS Threshold Analysis

CMS has stated that the agency does not agree with the RUC recommendation to use the dominant specialty approach in the PLI relative value methodology. However, CMS is interested in exploring a threshold analysis technique which would remove specialties from the calculation of PLI relative values for an individual CPT code when the specialty performs less than a certain percentage of the overall utilization (1%, 3%, or 5%).

**The PLI Workgroup recommends that the dominant approach should continue to be reiterated as a recommendation to CMS. The RUC recommends the dominant approach as the preferable method to select the risk factor to assign to each CPT code. However, in responding to the CMS request to review the various threshold levels, the RUC should recommend the 5% level to CMS as it most closely reflects the dominant approach. The RUC considers the recommendation to implement a threshold as an interim step and will continue to advocate the dominant approach.**

#### Consider ASSH Request for Change in PLI Risk Factor Assignment

The American Society for Surgery of the Hand (ASSH) requested that the RUC submit a recommendation to CMS that the PLI premium data for hand surgery of \$28,974 (determined utilizing rating manuals from five insurers) is not appropriate. The ASSH noted that 70% of their members are orthopaedic surgeons and their premium data would be reflective of orthopaedic surgery without spine. The PLI Workgroup agreed and supports a RUC recommendation to CMS.

**The PLI Workgroup recommends that a letter be submitted to CMS advocating a change in the PLI risk factor for hand surgery. Hand surgery should be crosswalked to orthopaedic surgery (without spine). The PLI Workgroup has requested that ASSH provide additional support (ie, a letter) that indeed most hand surgeons are orthopaedic surgeons and incur the same PLI premiums as orthopaedic surgeons.**

### Update on PLI Premium Collection Efforts

Doctors Michael Maves and William Rich sent a letter on April 1, 2005 to the President of the Physician Insurers Association of America (PIAA) expressing the AMA and RUC appreciation for their assistance in updating the PLI premium data utilized by CMS in the PLI methodology.

Doctors Gregory Przybylski, Stephen Kamenetzky, and AMA staff met with CMS staff via conference call in late March to discuss the potential inclusion of PIAA in a future data collection effort. CMS collects PLI premium data each three years when it updates the geographic practice cost indices (GPCIs). The PLI GPCIs are projected to be updated again on January 1, 2007. Therefore, CMS will need to have new data available in time for the 2006 rulemaking processes. CMS is working to renew their contract on PLI data collection. The AMA staff and representatives of the PLI Workgroup will continue to work with CMS on securing assistance from PIAA as CMS engages in a new data collection effort.

### Other Issues

Mary Foto, OTR informed the PLI Workgroup that the RUC HCPAC Review discussed the potential data collection of PLI premium data for non-MD/DO health professionals. The HCPAC has requested each of the organizations to provide information by September 1 on the availability of data for their members. The HCPAC will discuss this information at their September meeting.

Sherry Smith informed the PLI Workgroup that the AMA Board of Trustees will present a report on the PLI relative value methodology at the June 2005 AMA House of Delegates meeting. This report will be distributed to RUC members prior to this meeting.