AMA/Specialty RVS Update Committee
Meeting Minutes
April 26-29, 2007

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, April 26, 2007, at 11:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD
Dennis M. Beck, MD*
Michael D. Bishop, MD
James Blankenship, MD
Ronald Burd, MD
Manuel D. Cerqueira, MD*
Norman A. Cohen, MD
Thomas P. Cooper, MD*
Bruce Deitchman, MD*
John Derr, Jr., MD
Thomas A. Felger, MD
Mary Foto, OTR
Meghan Gerety, MD
Robert S. Gerstle, MD*
David F. Hitzeman, DO
Peter Hollmann, MD
Allan Inglis, Jr., MD*
Charles F. Koopmann, Jr., MD
Gregory Kwasny, MD
Walt Larimore, MD*
M. Douglas Leahy, MD*
Barbara Levy, MD
Brenda Lewis, DO*
J. Leonard Lichtenfeld, MD
William J. Mangold, Jr., MD*
Charles Mick, MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Gregory Przybylski, MD
Marc Raphaelson, MD*
Sandra B. Reed, MD*
David Regan, MD
James B. Regan, MD
Chad Rubin, MD*
Daniel Mark Siegel, MD
J. Baldwin Smith, III, MD
Peter Smith, MD
Susan Spires, MD*
Holly Stanley, MD*
Robert J. Stomel, MD*
Arthur Traugott, MD
Richard Tuck, MD
James Waldorf, MD*
George Williams, MD*
John A. Wilson, MD*

*Alternate

II. Chair's Report

Doctor Rich made the following general announcements:

- 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.
- Presenters are expected to announce any conflicts or potential conflicts, including travel reimbursement paid by an entity other than the specialty society, at the onset of their presentation.

- Before a presentation, any RUC member with a conflict must state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or advocate on behalf of their specialty.
- For new codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PERC recommendations or PEAC standards. If the society has not accepted PERC recommendations or standardized PE conventions, the tab will be immediately referred to a Facilitation Committee before any work relative value or practice expense discussion.
- The Summary of Recommendation form has been edited and includes a number of new questions, including modifier 51 status, PLI crosswalk and others. The RUC should provide feedback if sections of the summary are incorrect.
- All RUC Advisors presenting survey data are required to sign the attestation statement at the bottom of the Summary of Recommendation form.

- Doctor Rich welcomed the CMS Staff attending the meeting, including:
    - Edith Hambrick, MD, CMS Medical Officer
    - James Hart, Director of the Division of Outpatient Care
    - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
    - Ken Simon, MD, CMS Medical Officer
    - Pam West, PT, DPT, MPH, Health Insurance Specialist

- Doctor Rich welcomed the following Medicare Contractor Medical Director:
    - Charles Haley, MD

- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
    - Carol Carter

- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting were:
    - Bill Moran, MD (Chair)
    - Katherine Bradley, PhD, RN
    - Joel Brill, MD
    - Manuel D. Cerqueria, MD
    - Neal Cohen, MD
    - Thomas Felger, MD
    - Gregory Kwasny, MD
    - Peter McCreight, MD
    - James Regan, MD

- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee #1	Facilitation Committee #3
Gregory Kwasny, MD (Chair)	James Blankenship, MD (Chair)
Ronald Burd, MD	Bibb Allen, MD
Mary Foto, OTR	Michael Bishop, MD
Meghan Gerety, MD	Barbara Levy, MD
Bernard Pfeifer, MD	Charles Mick, MD
David Regan, MD	Allen Plummer, MD
Arthur Traugott, MD	J. Baldwin Smith, MD
Robert Vogelzang, MD	Lloyd Smith, DPM
	Bill Moran, MD

Facilitation Committee #2	Facilitation Committee #4
Susan Spires, MD (Chair)	James Regan, MD (Chair)
Neal Cohen, MD	Katherine Bradley, PhD, RN
John Derr, MD	Norman Cohen, MD
Thomas Felger, MD	John O. Gage, MD
Anthony Hamm, DC	David Hitzeman, DO
Charles Koopman, MD	J. Leonard Lichtenfeld, MD
James Maloney, MD	Daniel Mark Siegel, MD
William Mangold, Jr., MD	Peter Smith, MD
Gregory Przybylski, MD	Richard Tuck, MD

- Doctor Rich welcomed the following individuals as observers at the April 2006 meeting:
    - John Allen, American Gastroenterological Association
    - Chip Amoe, American Society of Anesthesiologists
    - Allan Anderson, American Psychiatric Association
    - Margie Andreae, American Academy of Pediatrics
    - William Beach, American Academy of Orthopaedic Surgeons
    - David Beyer, MD, American Society for Therapeutic Radiology and Oncology
    - Anne Marie Bicha, American Gastroenterological Association
    - Richard Brown, MD, American Psychiatric Association
    - Melissa Cacia, American Association of Clinical Endocrinologists
    - Scott Collins, MD, American Academy of Dermatology
    - Peter Conti, Society of Nuclear Medicine
    - William Creevy, MD, Orthopaedic Trauma Association
    - Maureen Dennis, American College of Radiology
    - Alan Desmond, American Academy of Audiology
    - Jane Dillion, MD, American Academy of Otolaryngology – Head and Neck Surgeons
    - Yolanda Doss, American Osteopathic Association
    - Meghann Dugan, American Society for Therapeutic Radiology and Oncology
    - Robert Fine, American Academy of Orthopaedic Surgeons

- Richard Fogel, American College of Cardiology
- Neal Freeman, American Academy of Ophthalmology
- Edward Fry, MD, American College of Cardiology
- Brian Galinat, American Urological Association
- Emily Gardner, Society of Nuclear Medicine
- Larry Gentilello, MD, American Psychiatric Association
- Richard Gilbert, MD, American Urological Association
- Lawrence Green, American Academy of Dermatology
- Janis Gregory, American Urological Association
- David Han, Society for Vascular Surgery
- William Hanke, MD, American Academy of Dermatology
- Robert Harris, American College of Obstetricians and Gynecologists
- Doug Huynh, Society of Interventional Radiology
- Robert Jasak, American Academy of Orthopaedic Surgeons
- Kirk Kanter, Society of Thoracic Surgeons
- Charles Kirkpatrick, American Academy of Allergy, Asthma & Immunology
- Debra Lansey, American Academy of Otolaryngology – Head and Neck Surgeons
- James Lingeman, American Urological Association
- Jennifer Markkanen, American Academy of Sleep Medicine
- Karra Markley, MD, College of American Pathologists
- Ted Martin, American College of Cardiology
- Edward Martin, American College of Cardiology
- Amy Melnick, American College of Cardiology
- Jennifer Mercurio, American Geriatrics Society
- Erika Miller, American College of Physicians
- Lisa Miller Jones, MS, American Academy of Audiology
- Keith Naunheim, Society of Thoracic Surgeons
- Gerald Niedzwiecki, MD, Society of Interventional Radiology
- Diane Pedulla, American Psychological Association
- Wayne Powell, American College of Cardiology
- Jeffrey Rich, Society of Thoracic Surgeons
- Paul Rudolf, MD, American Geratrics Society
- Debra Sedlak, Joint Council of Allergy Asthma and Immunology
- Bruce Shingleton, MD, American Urological Association
- Matthew Sideman, Society for Vascular Surgery
- Craig Sobolewski, American College of Obstetricians and Gynecologists
- James Startzell, American Association of Oral and Maxillofacial Surgeons
- Kay Sykes, American College of Surgeons
- Lynne Szott, RN, Joint Council of Allergy Asthma and Immunology
- Kate Thomas, American Academy of Audiology

- Carl Tommaso, MD, American College of Cardiology
- Sean Tutton, Society of Interventional Radiology
- Chris Welch, American Association of Clinical Endocrinologists
- Holly Whelan, The Endocrine Society
- Bruce Wilkoff, MD, American College of Cardiology
- Joanne Willer, American Academy of Orthopaedic Surgeons
- Kaivn William, American Osteopathic Association
- Kadyn Williams, American Audiology Association

III. Director's Report

Sherry Smith made the following announcements:

- AMA staff has distributed a meeting evaluation form to assess the quality of the RUC meeting. Ms. Smith asks all attendees to complete the form at the conclusion of the meeting and to leave it at the registration desk.

- Ms. Smith announced that several members of the RUC have been reappointed to the RUC by the specialty society in which he/she represents. The term for each RUC member is for three years, beginning with the September 2007 RUC meeting and ending in May 2010:
  - James Blankenship, MD, American College of Cardiology
  - John Derr, Jr, MD, American Society of Plastic Surgeons
  - Bernard Pfeifer, MD, American Academy of Orthopaedic Surgeons
  - Gregory Przybylski, MD, American Association of Neurological Surgeons
  - Richard H. Tuck, MD, FAAP, American Academy of Pediatrics

IV. Approval of Minutes for the February 1-4, 2007 RUC meeting

The RUC noted that on page 38, the intra-service physician time for code 99443 is incorrectly listed as 25 minutes rather than 20 minutes in the rationale and recommendation. The RUC amended the minutes to reflect the correct time of 20 minutes.

The RUC reviewed the minutes and accepted them as amended.

V. CPT Editorial Panel Update

Doctor Peter Hollmann made the following announcements:

- The next meeting of the CPT Editorial Panel will be June 7-10, 2007 in Austin, TX.

- The June meeting is the Annual Meeting of the Panel and in addition to relatively few coding proposals, the meeting will feature a number of additional sessions discussing such issues as Category II codes and performance measures.

VI. Centers for Medicare and Medicaid Services Update

Doctor Ken Simon made the following announcements:

- CMS is currently in the process of drafting the *Proposed Rule* regarding the physician payment schedule, targeted for publication in July 2007.
- CMS is still preparing for the launch of the PQRI program scheduled for July 1, 2007. The Agency has invested a significant amount of time and effort into the program and is continuing to prepare.
- Ms. Carolyn Mullen has announced her retirement from CMS and will no longer be attended the RUC meetings as a staff representative of CMS. Ms. Mullen thanked the RUC and was duly applauded for her service over the years.

VII. Physicians Quality Reporting Initiative (PQRI) Update

Doctor Susan Nedza provided a brief report and answered questions regarding the PQRI and the steps CMS has taken to implement the initiative. She first highlighted the progress of the initiative noting that PQRI is a pay for reporting program mandated by Congress, with the reporting period beginning July 1, 2007 and ending December 31, 2007. Participants in the program must report applicable quality measures 80% of the time or greater in order to qualify for a 1.5% bonus payment on total submitted allowable charges during the reporting period. CMS is working closely with the AMA, MGMA and specialty societies to provide educational outreach to physicians. CMS is also working with its carriers, contractors, and clearing houses to ensure that the quality reporting, performed in conjunction with claims, can be accurately processed. Doctor Nedza proceeded to answer numerous questions from RUC members summarized below.

If a patient is seen with multiple chronic conditions that have measures associated with them, but you perform a procedure that only relates to one of the measures, should you report all quality measures or only the one which corresponds to the procedure? In such a situation, the physicians should only report the measure that is associated with the service he/she has provided.

If a patient has received a procedure associated with a quality measure that is only to be performed once every 12 months and that patient is seen again within 12 months, does the quality measure need to be reported again? No. A physician

will not have to recode the measure each time patient is seen with the same associated condition.

Some physicians have weighed the potential bonus payment for 2007 and determined that the administrative costs to change claims forms and processes is not financially advantageous, as there is no guarantee that PQRI will continue into the future. What incentives are there to participate besides the bonus payment? The PQRI is funded only through 2007. However, CMS expects there to be a continuation of the program in some way for 2008 and potentially beyond. Those that do not participate in 2007 may find themselves playing catch up to participate in the future. CMS is utilizing a claims-based reporting system because it feels it is the most universal way to accommodate all physicians and practices with the least amount of financial burden. The issue of electronic medical records is recognized by CMS and steps are being taken to ensure that those with and without EMR have equal access and opportunity to participate in PQRI.

If a physician performs a routine "anniversary visit" which encompasses as many as seven or eight quality measures, can all of them be reported at one time? Yes. Physicians should report every measure that applies for any visit. CMS is ensuring that claims processors and the clearing houses can accommodate a large number of measures per claim. Additionally, paper forms with have ample room for numerous measures to be reported.

There appear to be significant software issues that will arise from this. How is CMS addressing this? CMS is meeting with clearing houses, vendors, software manufacturers, and others to ensure that they can process the claims. Physicians are encouraged to contact their vendors to inquire as well.

What are the plans to analyze the data collected and use it to improve patient care? CMS is required to review the data and hopes that the collection and processing of measures leads to improved patient care. Another consideration is in the development of the measures and their clinical significance in improving patient outcomes and patient care. Everyone involved in the process has a responsibility to ensure that the measures, the collection process, and incentives will positively affect patient care.

Some of the claims software will not allow a $0 charge. We have heard that a nominal charge may be listed, is this accurate? Yes. There will be a regulation coded in the near future detailing this. Currently, the PQRI FAQ recommends, where $0 charges are not allowed, that a charge of $1 or $0.01 be submitted, which will not be paid.

Performance measures will not automatically improve quality. Many surgical quality indicators do not have approved measures and others have measures that do not have sufficient data to support them. It can take as much as two years to

develop a measure which is prohibitive and/or can result in acceleration of the process at the risk of compromising the quality of the measure itself. This is a significant concern of CMS. It is necessary for measure developers to include more people in the development process. They must also consider cross-specialty measures and the inability of smaller societies to invest the time and money into developing measures. CMS is looking for specific feedback from societies on this topic. The 2007 PQRI should shed light on areas of the process that need to be improved.

Many private insurers accept quality measures that are reported through different processes. Is there any effort to consolidate the processes? Yes. This is a great concern for CMS and something they are already working on. The use of CPT Category II codes is intended to help the alignment of processes. In 2008, CMS will review the potential for registry-based reporting which may allow for a single method of collection that may be used by private insurers as well as Medicare and Medicaid.

VIII. Contractor Medical Director Update

Doctor Charles Haley updated the RUC on several issues related to Medicare Contractor Medical Directors (CMDs).

- Doctor Haley provided an explanation of the new Medicare Administrative Contracting (MAC) program established under Section 911 of the Medicare prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to be completed by October 2011. CMS will "fully and openly" compete MAC contracts which will result in fewer MACs, larger jurisdictions, and potential outside entrants. CMS will compete all contracts within the initial implementation timeline and then periodically re-compete them at least once every five years.
- He also commented that there are a number of transitions to contracting rules which may affect providers in the near future. Specifically, CMDs are now introducing a new accounting software, which may result in some time delays during the implementation phase, but ultimately result in a more efficient and accurate accounting systems for CMDs.
- National Provider Identification (NPI) numbers are to be implemented and used by all providers by May 23, 2007. While this was firm deadline, CMDs fully expect some waivers and/or time extensions to be issued and will recognize those extenuating circumstances.
- CMDs continue to discuss the implementation of ICD-10 and anticipate its introduction by 2010.
- CMDs expect there to be some difficulties with the implementation of the PQRI program in July. The CMDs do not anticipate problems from their end, but do understand that some clearing houses and physician offices will have difficulties transmitting the claims.

IX. Washington Update

Sharon McIlrath, AMA Assistant Director of Federal Affairs and Kurt Gillis, PhD, AMA Principal Economist, provided the RUC with the following announcements of the AMA's lobbying efforts:

- Ms. McIlrath and Dr. Gillis discussed the AMA's analysis of the 2006 volume and expenditure growth of Medicare Part B spending. In 2006, estimated spending growth was lower than in past years.
- Ms. McIlrath discussed the recent MedPAC report, mandated by Congress, regarding potential alternatives to the sustainable growth rate (SGR) formula, including how it relates to issues the RUC is addressing, and information about the CMS resources to make such changes. The report was mandated by Congress through provisions within the Deficit Reduction Act of 2005. Congress asked that MedPAC consider alternates including ways of removing or re-configuring the SGR to take into consideration one or more of the following: type of service, geographic location, practice size and type, and/or providers with significantly high utilization. The most significant potential changes included within the report are:
    - Bundling physician payments together by episode in order to reduce the incentive to increase volume of individual services.
    - Profiling physicians by comparing same-specialty physicians within the same geographic area for quality and efficiency.
    - Tying quality indicators and efficiency measures together and initiating a pay for performance system.
- The CMS Trustees have released their annual report which warns that in addition to the 10% cut in physician reimbursement projected for 2008, there will be additional cuts in each of the next eight years for a total of about 40% by 2016.
- Ms. McIlrath noted that there is a desire to fix the physician reimbursement problems in Congress, but the expense of a complete fix is staggering to many, projected at $262 billion over 10 years. Additional stop-gap measures may again be utilized in 2008.
- Congress may decide to reduce subsidies to Medicare Advantage plans which may help to alleviate some of the expenses.

X. Relative Value Recommendations for CPT 2008

Anesthesia for Radiologic Spine Procedures (Tab 4)
Tripti Kataria, MD, MPH, American Society of Anesthesiologists (ASA)

The CPT Editorial Panel created two new codes and deleted one existing code to clearly differentiate between anesthesia care for diagnostic and therapeutic radiological procedures on the spine.

The RUC reviewed the survey data for CPT code 01935 *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic.* The RUC agreed with the specialty that CPT code 01992 *Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position* (Base Unit=5.00) was an excellent reference for this code. Although the intra-service time of the surveyed code was higher than the reference code, 55 minutes and 30 minutes respectively, the intensity/complexity measures for these two procedures demonstrate that these two procedures require very similar intensity and complexity to perform. Therefore, the RUC agreed with the specialty society that the base unit for this procedure should be valued at 5.00 base units, the 25th percentile and median of the survey. **The RUC recommends 5.00 Base Units for 01935.**

The RUC reviewed the survey data for CPT code 01936 *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic.* The RUC noted that the reference code 00630 *Anesthesia for procedures in lumbar region; not otherwise specified* (Base Unit=8.00) had significantly more total service time associated with it compared to the surveyed code, 196 minutes and 115 minutes respectively. Conversely, the surveyed code demonstrated slightly higher intensity and complexity measures compared to the reference code. However, because this code is subject to work neutrality policy, the specialty society recommended the 5.00 Base Units for this procedure, which is the 25th percentile of their survey data. The RUC agreed with this rationale for valuation. **The RUC recommends 5.00 Base Units for 01936.**

Practice Expense:
The RUC recommends the anesthesiology practice expense standard of 8 minutes of clinical labor time consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination and completion of forms in the facility setting.

Soft Tissue Brachytherapy Implant Placement (Tab 5)
Najeeb Mohideen, MD, Michael Kuettel, MD, MBA, PhD, David Beyer, MD, American Society of Therapeutic Radiation Oncology (ASTRO)

In February 2007, the CPT Editorial Panel created a new Category I code to provide more specificity in describing the surgical placement of brachytherapy needles or catheters. The new code describes the placement of brachytherapy needles and/or catheters into muscle and/or soft tissue.

The RUC reviewed the specialty society's survey of 47 radiation oncologists for code 20555 *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)* and agreed that those surveyed had overestimated the pre-service

evaluation and positioning time associated in comparison to similar services. The RUC determined that code 20555 is similar in physician work, time and intensity to 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance* (work RVU = 6.00), which is the same value as the lowest work RVU response from the specialty's survey. The RUC also agreed that the physician time pre-service evaluation time should be similar to that of code 19298. **The RUC recommends the physician work relative value of 6.00 for code 20555.** (with a pre-service evaluation time of 30 minutes, positioning of 5 minutes,15 minutes for scrub, dress, and wait, intra-service time of 70 minutes, and an immediate post service time of 30 minutes.)

Practice Expense
The RUC recommends no direct practice expense inputs in the non-facility setting for this facility only service. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service.

External Fixation (Tab 6)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Creevy, MD, Orthopaedic Trauma Association (OTA), William Beach, MD, AAOS

At the February 2007 CPT Editorial Panel meeting, the Panel accepted the request to establish two codes: 20695 *Stereotactic computer-assisted adjustment of multi-planar dynamic external fixation system (eg, spatial frame), including imaging; initial alignment, assessment and computation of adjustment schedule(s)*and 20696 *Stereotactic computer-assisted adjustment of multi-planar dynamic external fixation system (eg, spatial frame), including imaging; exchange of each strut* to report stereotactic, computer-assisted adjustment of multiplanar dynamic external fixation systems. In consideration of this request at the April 2007 RUC meeting, it was recommended, at the request of the specialties, that the codes be rescinded. This action would allow the specialties the opportunity to revise the descriptors to more accurately describe the service specifically to clarify that the computerized schedule is distinct from the application of the fixation device. The CPT Executive Committee reviewed this request made by the specialty society and the RUC and agreed that these codes should be rescinded. **The CPT Executive Committee rescinds CPT codes 20695 and 20696.**

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* be removed from the Modifier -51 Exempt List. The Workgroup

asked specialty societies to review the list and bring back any code they believed should be retained on the list. At the February 2007 CPT meeting, the specialty societies asked to retain 20690 and 20692 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 20690 and 20962 to the RUC. The RUC understands that it is tasked with considering whether 20690 and 20692 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 20690 and 20692.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of these services and the history of their value. The specialty societies and the RUC understood that both of these services have significant time in the pre-service and post service periods which would disqualify 20690 and 20692 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

As both of these procedures have significant pre-service and post-service times associated with them, the RUC agreed with the specialty society that these codes should be valued as stand alone procedures and should be removed from the Modifier -51 Exempt List. **The RUC concurs with the CPT Editorial Panel that 20690 and 20692 be removed from the Modifier -51 Exempt List.**

As the RUC works under the presumption that all services on the physician fee-schedule are correctly valued, the specialty society provided compelling evidence to support its recommendation of 8.65 RVUs for 20690 and 16.00 RVUs for 20692, which is an increase over the existing value of 20690 and 20692, 3.67 and 6.40 RVUs respectively. The specialty society explained that the codes had never been reviewed by the RUC as 090 day global procedure.

In the Harvard submission to CMS in March 1992 , code 20690 was studied as a 090-day global. However CMS shose not to use the Harvard data and the 1992 MFS published RVW was 3.71 with a ZZZ global period. From 1992 to 1999 (interim), the global period was ZZZ. From 1999 to present, the global period is 090. No explanation was provided in any Federal Register text about this change. A similar history exists for CPT code 20692. In the Harvard submission to CMS in March 1992, code 20692 was studied as a 090-day global code The 1992 MFS published RVW was 6.76 with a ZZZ-day global period. Additional sources confirm a ZZZ global period through 1998. From 1999 to present, the global period is 090. No explanation was provided in any Federal Register text about this change.

Given this history, it is clear that the current values and time information are not related to a code with a 90-day global period. Additionally, it is clear that these codes have never been properly reviewed by the RUC. The RUC reviewed this compelling evidence and agreed with the specialty that there is evidence that incorrect assumptions were made in the previous valuation of the service.

The RUC reviewed the specialty societies' survey results for 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and thoroughly discussed the physician time and work associated with this service in comparison to its reference code 24566 *Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation* (Work RVU=8.86). The specialty society modified the pre-service time associated with the surveyed code to better reflect the pre-service time evaluation associated with this procedure. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is the same as the surveyed code, 60 minutes. Additionally, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires more overall intensity to perform than the surveyed code. Therefore, the RUC agreed that because of the same amount of intra-service time and the greater overall intensity associated with the reference code in comparison to the surveyed code, the RUC recommends the 25th percentile of the survey data, 8.65 RVUs for 20690. The RUC believes that this value appropriately places the surveyed code in comparison to the reference code. **The RUC recommends 8.65 work RVUs for 20690.**

The RUC reviewed the specialty societies' survey results for 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)* and thoroughly discussed the physician time and work associated with this service in comparison to its reference code 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (*Work RVU=23.04). The specialty societies modified the post-operative visits associated with the surveyed code to better reflect the post-operative care associated with this procedure. After considerable review, the specialty societies offered another reference code as they

believed the reference code selected by the survey respondents was not appropriate. The specialty societies proposed CPT code 20664 *Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta), requiring general anesthesia* (Work RVU=9.86). The specialty society stated that 20692 had significantly more total time associated with it in comparison to the proposed reference code, 474 minutes and 405 minutes, respectively. Further, the specialty societies agreed that 20692 was a significantly more complex procedure to perform than 20664. Therefore, the RUC agreed that because the surveyed code has significantly more total service time associated with it and the greater overall intensity associated with the surveyed code in comparison to the proposed reference code, the RUC recommends the 25th percentile of the survey data, 16.00 RVUs for 20692. The RUC believes that this value appropriately places the surveyed code in comparison to the reference code. **The RUC recommends 16.00 work RVUs for 20692.**

Practice Expense:
The RUC reviewed the specialty societies recommended practice expense inputs for 20690 and 20692. The RUC noted that the specialty societies recommended the standard 090 day global practice expense input packages for these procedures. However, the specialty recommended and the RUC agreed that the pre-service time for 20690 performed in the facility be removed as this procedure is typically emergent. The revised practice expense recommendation are attached.

Computer Navigation (Tab 7)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Creevy, MD, Orthopaedic Trauma Association (OTA), Richard Wixson, MD, AAOS

The CPT Editorial Panel created three new Category I CPT codes in February 2007 to replace three Category III CPT codes used to describe computer assisted navigation for musculoskeletal surgical procedures. Since the establishment of the Category III codes, adequate evidence on the improved results with this technology have been published to warrant the conversion of these codes to Category I codes. The Panel also concluded that an add-on code was necessary to describe this extra effort since the use of this technology requires additional physician work, complexity and time beyond that normally involved in a musculoskeletal procedure.

20985
The RUC considered the specialty society survey results and presentation for CPT code 20985, *Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less*. The RUC reviewed the survey results in comparison to the key reference service code 22522, *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code*

for primary procedure), (work RVU = 4.30, intra-time = 50 minutes). The reference service code has significantly more intra-service time, 50 minutes compared to 20 minutes; however, the surveyed code requires much greater mental effort and judgment as well as technical skill and physical effort. Based on this comparison, the RUC agreed that the 25th percentile of the survey results (work RVU = 2.50), slightly more than half the work RVU of the reference service, was appropriate. The RUC agreed with the specialty society's recommendation of 10 minutes of pre-time, despite the fact that the service will be reported as a ZZZ global period, add-on procedure. Typically, ZZZ codes contain no pre- or post-service time. The presenters noted that 20985 differed from other add-on services with respect to pre-time because of the significant time and effort required to initiate and calibrate computer navigation equipment as well as additional patient positioning time for the computer navigation to be used. However, as an add-on procedure, the RUC disagreed with the specialty society's recommendation to include five minutes of post-service time. The time was considered duplicative of any post-time which would be included in the procedure codes reported with code 20985. The time was revised to pre-service time of 10 minutes, intra-service time of 20 minutes and post-service time of zero minutes for CPT code 20985. **The RUC recommends a work RVU of 2.50 for CPT code 20985.**

The RUC recommends no practice expense inputs for this add-on code.

The RUC also noted that the service used for professional liability insurance (PLI) crosswalk for CPT code 20985 (CPT code 22522) has a work RVU of nearly twice its recommended work RVU. As such, the RUC recommended a more appropriate PLI reference service, 22103, *Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)*, (work RVU = 2.34).

20986

The RUC considered the specialty society survey results and recommendations for CPT code 20986, *Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less; with image-guidance based on intra-operatively obtained images (eg fluoroscopy, ultrasound)*. Because of the low response rate (n = 21) and the service performance rate (median = 0), the RUC concluded that the survey results were unreliable and could not make an appropriate recommendation of physician work based on these data. As such, the RUC agreed that the service should be interim valued as carrier priced and requested that the specialty society re-survey CPT code 20986 for the September 2007 RUC meeting. **The RUC recommends that CPT code 20986 be interim valued as carrier priced.**

20987
The RUC considered the specialty society survey results and recommendations for CPT code 20987, *Computer assisted surgical navigational procedure for musculoskeletal procedures; image-less; with image-guidance based on pre-operative images (eg, CT, MRI).* Because of the low response rate (n = 21) and the service performance rate (median = 0), the RUC concluded that the survey results were unreliable and could not make an appropriate recommendation of physician work based on these data. As such, the RUC agreed that the service should be interim valued as carrier priced and requested that the specialty society re-survey CPT code 20987 for the September 2007 RUC meeting. **The RUC recommends that CPT code 20987 be interim valued as carrier priced.**

New Technology
Because of the new codes were developed from Category III CPT codes, the low survey response rates, and at the request of the specialty society, **the RUC recommends codes 20985, 20986, and 20987 be added to the New Technology list.**

Interstitial Fiducial Marker Placement (Tab 8)
Robert Vogelzang, MD Society for Interventional Radiology (SIR), Sean Tutton, MD, Geraldine McGinty, MD, American College of Radiology (ACR), Jonathan W. Berlin, MD

The CPT Editorial Panel created three new codes to describe the implantation of fiducial markers, electromagnetic transducers or dosimeters to localize tumors during image-guided radiotherapy in the head or neck, intra-thoracically or intra-abdominally.

The Society of Interventional Radiology (SIR) and American College of Radiology (ACR) surveyed the interstitial fiducial marker placement codes. However, the survey response rates were low, with four to eight respondents per code. SIR indicated that this procedure is rarely performed and does not meet the criteria to be a category I code as being widely performed. The American Society for Therapeutic Radiology and Oncology (ASTRO) representatives indicated that these procedures are performed in conjunction with radiation therapy, particularly SBRT, and the low response rate could likely be attributed the use of a random survey sample that didn't reach the appropriate audience. The RUC was concerned that the CPT coding proposal and RUC testimony on volume were inconsistent. **The RUC agreed that the survey data was not representative and determined that they could not develop work RVU recommendations based on this data. The RUC referred codes 21112, 21520, and 49437 back to CPT. The CPT Executive Committee rescinded these codes for *CPT 2008* and specialty societies will need to submit a new coding proposal to CPT in order to create new Category I CPT codes for interstitial fiducial marker placement.**

Three Column Osteotomy (Tab 9)
Frederick Boop, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS), R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), Claire Tibiletti, MD North American Spine Society (NASS)

In February 2007, the CPT Editorial Panel created three new Category I CPT codes to describe a group of procedures to address osteotomies performed through one column of the spine (the posterior column). Advances in surgical technique, instrumentation and intra-operative hemodynamic management have allowed for osteotomies that go through all three columns to be performed from a posterior approach. Three column osteotomies take significantly more time to perform and are associated with additional risk. Three CPT codes needed to be developed to address more complex deformities and allow greater degrees of correction than single column osteotomies.

22206
The RUC reviewed the specialty societies' survey results and presentation for code 22206, *Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic*. The randomized survey, completed by 80 neurological surgeons and orthopaedic surgeons representing spine and general orthopaedics, was reviewed by an expert panel to ensure accuracy, validity and relativity of the survey results. The specialties and the RUC agree that the survey's median pre-, intra-, and post-service times as well as the post-operative visits required for this intense procedure were accurate. The RUC also reviewed the key reference service selected by nearly half of the survey respondents, 63101, *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment* (work RVU = 33.92). The RUC noted that the reference service contained significantly less intra-service time than the surveyed code, 215 minutes versus 300 minutes, respectively. In addition to this difference with the reference service, the surveyed code requires significantly more intensity and complexity in technical skill, risk of complications, judgment of the physician, and malpractice risk. Based on the quality of the survey data presented and relativity to the key reference service, the RUC agreed with the specialty societies' recommendation of the survey median RVU of 37.00. **The RUC recommends the survey median work RVU of 37.00 for code 22206.**

22207
The RUC reviewed the specialty societies' survey results and presentation for code 22207, *Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); lumbar*. The randomized survey, completed by 80 neurological surgeons and orthopaedic surgeons representing spine and general orthopaedics, was reviewed by an expert

panel to ensure accuracy, validity and relativity of the survey results. The specialties and the RUC agree that the survey's median pre-, intra-, and post-service times as well as the post-operative visits required for this intense procedure were accurate. The RUC also reviewed the key reference service selected by more than half of the survey respondents, 63087, *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment* (work RVU = 37.38). The RUC noted that the reference service contained less intra-service time than the surveyed code, 265 minutes versus 300 minutes. Additionally, the surveyed code requires only slightly more mental effort and judgment, technical skill, physical effort, psychological stress, and intensity/complexity per time segment than the reference service. Based on the quality of the survey data presented and relativity to the key reference service, the RUC agreed with the specialty societies' recommendation of the survey median RVU of 36.50. **The RUC recommends the survey median work RVU of 36.50 for code 22207.**

22208

The RUC reviewed the specialty societies' survey results and presentation for code 22208, *Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to primary procedure)*. The RUC also reviewed the key reference service, 22216, *Osteotomy of spine, posterior or posterolateral approach, one vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)*, (work RVU = 6.03), in relation to the surveyed code and noted that the reference service required only half of the intra-service time, 60 minutes versus 120 minutes. In addition to the broad difference in time, the surveyed code also requires greater intensity and complexity to perform. The RUC agreed that the median work RVU from the specialty societies' survey, compared to the key reference service, was justified. However, as an add-on service with a global period of ZZZ, the RUC found there to be duplicative work described in the pre-service and intra-service times. The presenters agreed with the RUC regarding pre-time and recommended a reduction in the work RVUs consistent with the duplicative time accounted for in the pre-service period. Using an IWPUT calculation or building block methodology, the RUC backed-out the work RVUs associated with the 15 minutes of pre-service time originally proposed by the specialty and removed the 15 minutes from the service. Multiplying the time by the intensity associated with pre-service time (10 minutes of pre-service evaluation time at 0.0224 and 5 minutes of pre-service positioning time also at 0.0224), resulted in a reduction of 0.34 work RVUs [15 minutes x 0.0224 = 0.34] from the survey median RVU, accounting for a recommended work RVU of 9.66 [10.00 – 0.34 = 9.66]. The RUC recommends a pre-service time of 0 minutes, intra-service time of 120 minutes, and immediate post-service time of 15 minutes. **The RUC recommends a work RVU of 9.66 for code 22208.**

Practice Expense
The RUC recommends the practice expense inputs as amended by the PERC in the facility setting for 22206-22208, removing duplicative clinical staff time in the pre-service period.

Epicondylitis Procedures (Tab 10)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS)

The CPT Editorial Panel, in February 2007, replaced the existing five epicondylitis procedure codes with three clearer descriptions of the services. The Panel agreed that the five descriptions are confusing, difficult to specify varied situations, and, in some cases, clinically irrelevant. The three new codes, which describe the same work, were developed to clearly describe the work involved in the epicondylitis procedures as well as additional work that may or may not be required in such procedures.

24357
The RUC discussed the specialty societies' survey results and presentation for 24357, *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous*. The new code was compared to reference service 25651, *Percutaneous skeletal fixation of ulnar styloid fracture*, (work RVU = 5.68). The two services have identical intra-service time (20 minutes), while the surveyed code requires slightly less intensity and complexity. As such, the specialty society and the RUC agreed that the survey median of 5.68 RVUs was too high. The RUC also compared the service to the code with which it was previously billed, 24350, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis)*, (work RVU = 5.32). Because the service does not represent new work, the RUC agreed that a work RVU of 5.32 was appropriate. Further, 5.32 falls midway between the 25th percentile and the median of the survey results, providing greater rationale for the recommended work RVU. The RUC determined that the single 99213 office visit overstated the work involved in the visit; however, a total of four office visits was appropriate. The RUC, therefore, reduced the single 99213 office visit to a 99212 office visit accounting for a total of four level two office visits within the service's global period. The RUC discussed the pre-service time and noted that the 15 minutes allotted for scrub, dress and wait time was excessive. Subsequently, the RUC recommended a reduction in this pre-service time category to the standard of 10 minutes, reducing total pre-service time to 50 minutes. The RUC recommends a pre-service time of 50 minutes, intra-service time of 20 minutes, and immediate post-service time of 15 minutes as well as one-half 99238 discharge day management and four 99212 office visits for code 24357. **The RUC recommends a work RVU of 5.32 for code 24357.**

24358

The RUC discussed the specialty societies' survey results and presentation for 24358, *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous; open, debridement, soft tissue and/or bone*. The new code was compared to reference service 25109, *Excision of tendon, forearm and/or wrist, flexor or extensor, each,* (work RVU = 6.81). The two services have identical intra-service and post-service times (intra = 40 and post = 20 minutes), and the surveyed code requires similar intensity and complexity as compared to the reference code. As such, the specialty society and the RUC agreed that the survey median of 6.81 RVUs was too high, while the 25th percentile was too low. The RUC also compared the service to codes with which it was previously billed, 24351, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment*, (work RVU = 5.97), 24352, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with annular ligament resection*, (work RVU = 6.49); 24354, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping*, (work RVU = 6.54); and 24356, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy* (work RVU = 6.74). Because the service does not represent new work, the RUC agreed that a weighted average for the previously billed services would assist in the recommendation of an appropriate work RVU (calculation shown below). The resulting work RVU is 6.54. Further, 6.54 falls midway between the 25th percentile and the median of the survey results, providing greater rationale for the recommended work RVU. The RUC determined that the single 99213 office visit overstated the work involved in the visit; however, a total of four office visits was appropriate. The RUC, therefore, reduced the single level three office visit to a 99212 office visit accounting for a total of four 99212 office visits within the service's global period. The RUC discussed the pre-service time and noted that the 15 minutes allotted for scrub, dress and wait time was excessive. Subsequently, the RUC recommended a reduction in this pre-service time category to the standard of 10 minutes, reducing total pre-service time to 50 minutes. The RUC recommends a pre-service time of 50 minutes, intra-service time of 40 minutes, and immediate post-service time of 20 minutes for code 24358. **The RUC recommends a work RVU of 6.54 for code 24358.**

Surveyed Service	Previously Billed Service	2007 work RVU	2005 Medicare Frequency	Total work RVUs	Work RVU x Freq. %	Weighted Average
24358	24351	5.97	326 (24%)	1946	1.43	**6.54**
	24352	6.49	35 (3%)	227	0.20	
	24354	6.54	68 (5%)	445	0.33	
	24356	6.74	925 (68%)	6235	4.58	
			1,354 (Total)	8,853 (Total)		

24359

The RUC discussed the specialty societies' survey results and presentation for 24359, *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); open, debridement, soft tissue and/or bone, with tendon repair or reattachment*. The new code was compared to reference service 24343, *Repair lateral collateral ligament, elbow, with local tissue* (work RVU = 8.99). The reference service has a greater amount of intra-service and post-service time as compared to the surveyed code (intra = 90 and 30 minutes and post = 60 and 20 minutes). However, the surveyed code requires greater physical effort, urgency of decision making, and more intense pre-service work. As such, the RUC agreed that the surveyed code should be valued slightly lower than the reference service and agreed with the specialty society recommendation of the 25th percentile of the survey data work RVU of 8.86. The RUC also noted that previously, 24359 would have been billed in one of three ways, 1) using both 24341, *Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)* (work RVU = 9.24) and 24356, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with partial ostectomy*, (work RVU = 6.74) resulting in a total work RVU of 12.61 accounting for the multiple procedure reduction; or 2) using both 24341, *Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)* (work RVU = 9.24) and 24351, *Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with extensor origin detachment* (work RVU = 5.97), resulting in a total work RVU of 12.23 accounting for the multiple procedure reduction. The recommended value also retains neutrality of work within the family of services. The RUC determined that the single 99213 office visit overstated the work involved in the visit; however, a total of four office visits was appropriate. The RUC, therefore, reduced the single 99213 office visit to a 99212 office visit accounting for a total of four 99212 office visits within the service's global period. The RUC discussed the pre-service time and noted that the 15 minutes allotted for scrub, dress and wait time was excessive. Subsequently, the RUC recommended a reduction in this pre-service time category to the standard of 10 minutes, reducing total pre-service time to 50 minutes. The RUC recommends a pre-service time of 50 minutes, intra-service time of 60 minutes, and immediate post-service time of 20 minutes for code 24359. **The RUC recommends a work RVU of 8.86 for code 24359.**

Practice Expense

The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

Work Neutrality

The work described in 24357-24359 does not constitute new physician work and is subject to work neutrality constraints. The RUC calculated and determined that the new work RVUs will maintain neutrality of work within the family

Femoral Head Fracture Treatment (Tab 11)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Creevy, MD, AAOS

The CPT Editorial Panel created three new Category I CPT codes to describe services performed by orthopedists that are distinctly different from the treatment of other proximal femoral fractures, involving the femoral neck, intertrochanteric or subtrochanteric regions. Whereas these other fractures do not involve the femoral head (i.e. the cartilage covered "ball" of the hip joint's "ball joint articulation") fractures of the femoral head are both intraarticular and intracapsular by definition. These injuries may involve any part of the femoral head. Displaced fractures, especially those involving the superior head, place the hip joint at grave risk for developing osteoarthritis (degeneration of the joint) as the weight bearing portion is affected directly. New codes are necessary to reflect the management of these patients and the varied injury patterns that have been described. An open treatment code is required as the procedure is distinctly different from the treatment of other proximal femoral fractures as fractures of the head usually require a hip arthrotomy with a surgical dislocation of the hip to affect a repair and place internal fixation.

The specialty societies surveying CPT codes 27267, *Closed treatment of femoral fracture, proximal end, head; without manipulation*; 27268, *Closed treatment of femoral fracture, proximal end, head; with manipulation*; and 27269, *Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed,* commented and the RUC agreed that the vignettes were confusing and required further refinement by the CPT Editorial Panel. The survey respondents indicated they were unable to determine what if any work was involved in the procedure and the survey results were problematic in that most respondents were unable to identify any time in the pre-, intra- or post-service procedures because they agreed, that the vignette was potentially flawed. The RUC decided to refer the codes to the Editorial Panel for refinement of the vignettes and request that once the revised vignettes are finalized that the specialty societies re-survey the services for review by the RUC at the September 2007 RUC meeting. **In the interim, the RUC agreed that it was appropriate for the services to be carrier priced**.

Internal or External Fixation-Hip and Knee (Tab 12)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Creevy, MD, AAOS

As part of the 2005 Five-Year Review Process, the American Academy of Orthopaedic Surgery (AAOS) commented that the compelling evidence rationale for examining the work RVU for the fracture treatment codes is that there is evidence that incorrect assumptions were made in the valuation of these codes due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the

previous valuation for the code included the situation when internal and external fixation is applied to a fracture site. Therefore, the RUC recommended that these codes be referred to the CPT Editorial Panel for further clarification.

At the October 2006 CPT Editorial Panel Meeting, the AAOS recommended to the CPT Editorial Panel that the identified fracture treatment codes in the musculoskeletal section of CPT that include the nomenclature "internal or external" fixation should be clarified to state that external fixation should be an adjunctive procedure to these procedures. The CPT Editorial Panel agreed with the specialty society that these codes needed to be clarified and reference to external fixation should be removed from 64 CPT codes. These 64 codes were divided into four categories based on location: Shoulder/Elbow, Elbow/Hand, Hip/Knee and Foot/Ankle. At the February 2007 RUC Meeting, three of these categories were discussed: Shoulder/Elbow, Elbow/Hand and Foot/Ankle. These recommendations specifically detail the RUC's recommendations for the Hip/Knee codes as discussed at the April 2007 RUC Meeting.

Approximately 150 orthopaedic providers participated in each of the surveys. These respondents included physicians from general orthopaedic surgery, orthopaedic trauma surgery and hip and knee surgery. After the results from all of these groups were tabulated, a consensus committee of physicians representing the American Academy of Orthopaedic Surgeons, American Association of Hip and Knee Surgeons and Orthopaedic Trauma Association met to discuss the survey data for the revised orthopaedic codes.

The RUC reviewed the compelling evidence for these procedures. The specialty societies claimed that because the CPT descriptors originally contained the phrase "with or without internal or external fixation," it is difficult to imagine what the original Harvard survey data actually represented. Furthermore, an Abt study was performed in 1992 for RUC consideration. This study produced percentage relationships to key reference codes, but not surveyed time and visit data. Some of these recommendations were accepted by the RUC and CMS and others were adjusted up or down but no changes were made to the Harvard time and visit data, if available. Therefore, the specialty society believes that there is little, if any, relationship between the Harvard database time and visit information and the current work RVUs.

Furthermore, the specialty societies stated that there was a significant change in the technology for how these procedures are performed. The surgical treatments use open anatomical reduction and internal fixation has been made more complex with the introduction of new imaging methods such as computed tomography which allows better detection of the fracture pathology and provides the basis for new surgical strategies. Further, the patient population has changed, as women over 50 are a fast growing segment of the population. A huge percentage of these patients are osteoporatic – making fracture fixation and maintenance of fixation far more difficult. The specialty societies conducted a full RUC survey of all codes, and for

over half of the codes, recommended the 25th percentile or the median RVU of the specialty survey data. It should also be noted that the RUC is recommending the current work RVUs for two codes of the codes in this family, 27519 and 27540.

The RUC thoroughly reviewed these codes, and as part of this review, the specialty societies explained that they felt strongly that a 99233 hospital visit was appropriate for all of the codes within this family however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialty societies explained that they felt strongly that three 99213 office visits were appropriate for all of the codes within this family and however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC also reviewed CPT code 20690 *Application of a uniplane (pins or wires in one plane), unilateral, external fixation system* and 20692 *Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)*. It is the RUC's understanding that the utilization for these two procedures will not change with this coding change made by the CPT Editorial Panel. Therefore, the RUC determined that there will be no work neutrality impact for these recommendations. However, the RUC welcomes a retrospective review of this issue in the future.

27248 *Open treatment of greater trochanteric fracture, includes internal fixation, when performed*

The RUC reviewed CPT code 27248 and compared it with 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU=17.43). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is significantly greater than the surveyed code, 90 minutes and 60 minutes respectively. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater mental effort and judgment and more overall intensity to perform than the surveyed code. Therefore, the RUC agreed that because of the greater amount of time and the greater mental effort and judgment associated with the reference code in comparison to the surveyed code, the RUC recommends the 25th percentile of the survey data minus the work RVU associated with the amended post-operative visits, 12.83 RVUs for 27248. **The RUC recommends 12.83 work RVUs for 27248.**

27511 *Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed*

The RUC reviewed CPT code 27511 and compared it with 27477 *Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal* (work RVU=23.04). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is slightly greater than the surveyed code, 124 minutes and 120 minutes respectively. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater physical effort and judgment and more overall intensity to perform than the surveyed code. Therefore, the RUC agreed that because of the greater amount of time and the greater physical effort and overall higher intensity to perform associated with the reference code in comparison to the surveyed code, the RUC recommends the 25th percentile of the survey data, 18.05 RVUs for 27511. **The RUC recommends 18.05 work RVUs for 27511.**

27513 *Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed*

The RUC reviewed CPT code 27513 and compared it with 27477 *Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal* (work RVU=23.04). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total service time for the reference code and the surveyed code is very similar, 469 minutes and 464 minutes respectively. Furthermore, the RUC agreed with the specialty that although when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater physical effort and judgment and more overall intensity to perform than the reference code that both procedures have similar intensity. Therefore, the RUC agreed that because of the similar amount of total service time and similar intensities between the reference code and the surveyed

code, that these two codes should be valued the same, 23.04 RVUs. **The RUC recommends the median of the survey data, 23.04 work RVUs for 27513.**

27514 *Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed*

The RUC reviewed CPT code 27514 and compared it with 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU=17.43). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code and the surveyed code were the same, 90 minutes. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires similar overall intensity to perform as compared to the surveyed code. Therefore, the RUC agreed that because of the same amount of intra-service time and overall similar intensity to perform the surveyed code should be valued the same as the reference code, 17.43 RVUs. **The RUC recommends the 25th percentile of the survey data, 17.43 work RVUs for 27514**.

27519 *Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed*

The RUC reviewed CPT code 27519 and compared it with 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU=17.43). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total-service time for the reference code is significantly greater than the surveyed code, 473 minutes and 359 minutes respectively. However, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater physical effort and judgment and more overall intensity to perform than the reference code. Therefore, the specialty society recommended that the current value be maintained for this code as the

current value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference code 27236. The RUC agreed with the specialty society and recommends that the surveyed times and visits be applied to this code and its current value should be maintained. **The RUC recommends maintaining the current value of 15.80 work RVUs for 27519.**

27535 *Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed*

The RUC reviewed CPT code 27535 and compared it with 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU=17.43). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total service time for the reference code is significantly greater than the surveyed code, 473 minutes and 389 minutes. Furthermore, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater overall intensity to perform as compared to the surveyed code. Therefore, the RUC agreed that because of the greater amount of total service time and the higher amount of overall intensity to perform of the reference code as compared to the surveyed code, the surveyed code should be valued at the surveyed 25th percentile, 16.00 RVUs. **The RUC recommends 16.00 work RVUs for 27535**.

27540 *Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed*

The RUC reviewed CPT code 27540 and compared it with 29833 *Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)* (work RVU=11.61). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the total-service time for the surveyed code is significantly greater than the reference code, 334 minutes and 311 minutes respectively. Further, the RUC noted that when comparing the intensity/complexity measures of the surveyed

code to the reference code that the surveyed code requires greater physical effort and judgment and more overall intensity to perform than the reference code. The specialty society recommended that the surveyed code should be valued higher than the reference code based on these survey results but believed that the 25th percentile and median RVU value of the survey data both over-estimated the value of this procedure and would create rank-order anomalies with the other knee and hip fracture codes. The RUC agreed with the specialty society and recommends that the surveyed times and visits be applied to this code and its current value should be maintained. **The RUC recommends maintaining the current value of 13.45 work RVUs for 27540.**

27556 *Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction*

The RUC reviewed CPT code 27556 and compared it with 27415 *Osteochondral allograft, knee, open* (work RVU=19.79). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is significantly greater than the surveyed code, 120 minutes and 90 minutes respectively. Further, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater mental effort and judgment and more overall intensity to perform than the surveyed code. Therefore, the RUC recommends the 25th percentile of the RVU value of the survey data or 15.50 RVU for 27556. This value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference code 27415. **The RUC recommends 15.50 work RVUs for 27556.**

27557 *Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair*

The RUC reviewed CPT code 27557 and compared it with 27415 *Osteochondral allograft, knee, open* (work RVU=19.79). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The

RUC compared the service times of both procedures and noted that the total-service time for the reference code is significantly greater than the surveyed code, 424 minutes and 399 minutes respectively. However, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the surveyed code requires greater physical effort and psychological judgment and more overall intensity to perform than the reference code. Therefore, the specialty society recommended that the 25th percentile of the work RVU of the survey data for this code, 19.00 RVUs. This value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference code 27415. The RUC agreed with the specialty society and recommends that the surveyed times and visits be applied to this code and the current value should be 19.00 RVUs. **The RUC recommends 19.00 work RVUs for 27557.**

27558 *Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction*

The RUC reviewed CPT code 27558 and compared it with 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU=30.13). The RUC reviewed the proposed post-operative visits associated with the surveyed procedure and although the specialties explained that they felt strongly that a 99233 hospital visit was appropriate for this procedure, based on discussions at the RUC meeting, the specialty agreed to lower the intensity of this visit to a 99232 hospital visit. Additionally, the specialties explained that they felt strongly that three 99213 office visits were appropriate for this procedure however, based on discussions at the RUC meeting the specialty agreed to lower the intensity of two of these visits to two 99212 office visits. The RUC compared the service times of both procedures and noted that the intra-service time for the reference code is significantly greater than the surveyed code, 240 minutes and 150 minutes respectively. Further, the RUC noted that when comparing the intensity/complexity measures of the surveyed code to the reference code that the reference code requires greater mental effort and judgment and more overall intensity to perform than the surveyed code. Therefore, the RUC recommends the 25th percentile of the RVU value of the survey data or 22.00 RVU for 27558. This value maintains an appropriate relativity with the other knee and hip fracture codes as well as with the key reference code 27134. **The RUC recommends 22.00 work RVUs for 27558.**

Practice Expense:
The RUC recommends the standard 090 day global practice expense packages. The only exceptions to the standard 090 day global practice expense packages was where the procedure was considered to be emergent and the pre-service time allocated in the facility setting was removed.

Open Knee Osteochondral Autograft (Tab 13)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Beach, MD, AAOS

In February 2007, the CPT Editorial Panel created one new Category I CPT code to describe procedures not previously described in the family of osteochondral implantation CPT codes created in February 2004. These existing codes describe closed autograft, closed allograft, and open allograft techniques, but failed to describe open autograft technique. This new service describes the final combination of techniques.

The RUC reviewed the specialty society's survey results and recommendations for CPT code 27416, *Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])*. The RUC considered the surveyed code in comparison to the key reference service, 29866, *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)* (work RVU = 14.48). The RUC noted that the reference service has very similar pre-, intra- and post-service times. The reference service has slightly less pre-service time (75 versus 80 minutes) and slightly more intra-service time (100 versus 90 minutes), accounting for a difference in total time between the reference service and the surveyed service of only 5 minutes (292 versus 287 minutes). The survey results indicated a median of 19.00 work RVUs, which the specialty and RUC agreed was too high, given the similarity of the surveyed procedure with the reference service. The RUC concurred that the 25th percentile work RVU of 14.00 was appropriate for the work involved in the service and this value was below the reference service, maintaining proper rank order. Following some discussion, the RUC agreed that number and intensity of post-operative visits were appropriate (two 99213, two 99212, and 0.5 99238). **The RUC recommends the specialty society survey 25th percentile work RVU of 14.00 for code 27416.**

Practice Expense
The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

Posterior Malleolar Fracture Treatment (Tab 14)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Creevy, MD, AAOS, William Beach, MD, AAOS

In February 2007, the CPT Editorial Panel created three new Category I CPT codes to describe treatment of isolated, posterior malleolar fractures. Such treatments are recognized as being important in maintaining ankle joint stability and preventing or delaying the onset of degenerative arthritis. Prior to the creation of these codes, there were no codes describing closed or percutaneous treatment of these fractures, though codes exist for the treatment of a posterior malleolar fracture only when this fracture occurs with another malleolar injury (i.e., a lateral malleolus fracture or a

medial malleolus fracture ("bimalleolar" fracture) or both together ("trimalleolar" pattern)). This fracture is now recognized to occur in isolation (i.e. without involvement of either the lateral or medial malleolus). These three new codes were established to describe treatment for these isolated injuries.

27767

The RUC reviewed the specialty societies' survey results and presentation for CPT code 27767, *Closed treatment of posterior malleolus fracture; without manipulation*. The RUC compared the surveyed code to the reference service code, 27808, *Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation*, (work RVU = 2.91) and noted that the reference service had significantly more intra-service time than the surveyed code (15 minutes versus 37 minutes). The specialty societies commented that the physician time for code 27808 was not reviewed by the RUC and stated that the work described was similar and the intensity and complexity of both services were comparable. The RUC found that 26600, *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (work RVU = 2.48) was a more suitable reference code (included on the survey's reference service list). Code 26600 has been reviewed by the RUC and describes similar work. Additionally, the RUC reviewed intra-service time is identical to the surveyed code and each contains four office visits within their global periods. The total time for the surveyed code is slightly higher (96 minutes) than code 26600 (93 minutes). In tandem with this appropriate reference code, the survey's 25th percentile work RVU was 2.50, which the RUC agreed was the appropriate work RVU for 27767. **The RUC recommends the survey 25th percentile work RVU of 2.50 for code 27767.**

27768

The RUC reviewed the specialty societies' survey results and presentation for CPT code 27768, *Closed treatment of posterior malleolus fracture; with manipulation*. The RUC compared the surveyed code to the reference service code, 27810, *Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation* (work RVU = 5.20) and noted that the reference service had significantly more intra-service time than the surveyed code (25 minutes versus 52 minutes). The specialty societies commented that the physician service times for 27810 were not previously reviewed by the RUC, however, the work described was similar. Further, the surveyed code requires greater intensity and complexity than the reference service, particularly in mental effort and judgment, technical skill and physical effort, and psychological stress. The reference service and surveyed service require comparable pre- and post-service times (45 minutes versus 34 minutes) and nearly identical post-service time (10 minutes versus 11 minutes). Comparable to the reference service, the RUC agreed that the survey median of 5.00 work RVUs was appropriate for 27768. **The RUC recommends the survey median work RVU of 5.00 for code 27768.**

27769
The RUC reviewed the specialty societies' survey results and presentation for CPT code 27769, *Open treatment of posterior malleolus fracture; includes internal fixation, when performed*. The RUC compared the surveyed code to the reference service code, 25607, *Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation* (work RVU = 9.35). The RUC noted the similarity in pre-, intra-, and post-service times between the surveyed code and the reference code, 75, 60, and 15 minutes, versus 65, 60, and 30 minutes, respectively. The surveyed code also requires greater technical skill and physical effort as well as greater intra- and post- service time intensity/complexity. Given, the similarities, the RUC agreed that the reference service code was appropriate. The RUC also considered in-depth, the specialties' survey, noting that the survey was randomized with a relatively high number of responses (n = 48) and a sound response rate (24%). The RUC agreed that the tight distribution of work RVUs between the 25th and 75th percentiles gave credence to the survey median work RVU of 10.00. The RUC did, however, concur that the intensity of the office visits within the service's global period were overstated in the survey results. The RUC and the specialty societies agreed that the four visits were appropriate, but the visits should consist of three 99212 and only one 99213 office visits. The RUC recommends a pre-service time of 75 minutes, intra-service time of 60 minutes, and immediate post-service time of 15 minutes for code 27769. **The RUC recommends the survey median work RVU of 10.00 for code 27769.**

Practice Expense
The RUC recommends the practice expense inputs as amended in the non-facility setting for 27767, removing duplicative clinical staff time as well as the specialty societies' recommended inputs for 27768 and 27769, facility-only procedures, as they are standard 090 day global inputs.

Fibula Malunion (Tab 15)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Creevy, MD, AAOS, William Beach, MD, AAOS

At its February 2007 meeting, the CPT Editorial Panel created one new Category I CPT code to describe a service not currently included in CPT for repair of fibula with internal fixation. Current coding fails to address such a procedure when it is not performed with an osteotomy of the fibula or only when the fibula is repaired without open treatment of lateral malleolus.

The RUC reviewed the specialty societies' survey results describing the physician work for CPT code 27726, *Repair of fibula nonunion and/or malunion with internal fixation.* The RUC also reviewed the surveyed service in comparison to the key reference service, CPT code 27709, *Osteotomy; tibia and fibula* (work RVU = 17.32). While the survey data were reliable, the specialty societies and the RUC agreed that the survey median work RVU was too high, as the surveyed

service requires less time and is less intense than the reference service. In comparison to the key reference service, the surveyed service contains slightly less intra-service time, 100 minutes versus 108 minutes, respectively. Additionally, the surveyed code requires significantly less complexity and intensity, as survey respondents indicated a lower level of mental effort and judgment, technical skill and physical effort, and psychological stress required to perform the surveyed procedure. The RUC agreed that the number of post-operative hospital visits was appropriate; however, given the differences in intensity to the reference code, reasoned that the intensity of the visits should be lower. The specialty societies agreed and reduced one 99213 visit to one 99212, accounting for a total of three 99212 and one 99213 post-operative office visits. Based on this review, the RUC agreed with the specialty society recommendation of the surveyed 25th percentile work RVU of 14.20 for code 27726. **The RUC recommends the specialty societies' survey 25th percentile work RVU of 14.20 for code 27726.**

Practice Expense
The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

Open Osteochondral Talus Graft (Tab 16)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Beach, MD, AAOS, Lloyd Smith , DPM, American Podiatric Medical Association (APMA)

The CPT Editorial Panel created one new Category I CPT code in February 2007 to describe an open osteochondral autograft not presently included in CPT. Prior to this new code, the service was accounted for by using more general coding to describe only the incision of the tibia and/or fibula.

The RUC reviewed the specialty societies' survey results for CPT code 28446, *Open osteochondral autograft, talus (includes obtaining graft[s])*. The specialties commented that the service is a highly complex surgery representing only the most complex and difficult patient population. The key reference service, 29892, *Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)* (work RVU = 10.07) which was selected by 29% of respondents, differs significantly from the procedure surveyed. Given the low service performance rate (median = 4), the specialties convened an expert consensus panel consisting of general orthopaedics, arthroscopy, trauma, hip & knee, foot & ankle, total joint, and sports medicine specialists to review the survey data compared with the reference code and other orthopaedic and podiatric services and assess more closely the complexity of the procedure. The consensus panel agreed that the surveyed median intra-service time (90 minutes) and work RVU (16.00) were both too low. Rather, the panel believed that the 75th

percentile intra-service time (120 minutes) and work RVU (17.50) were an appropriate estimation of time and physician work. The specialty societies commented that the procedure involves three distinct procedures, malleolar osteotomy and repair, osteochondral transplantation of the talus, and harvesting of the osteochondral grafts from the knee. The physician work for similar codes describing each of these procedures far exceeds the 75th percentile of the survey median; code 29874, *Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)* (work RVW = 7.10); 29866, *Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft)* (work RVW = 14.48); and 27705, *Osteotomy; tibia* (work RVW= 10.74). If these three procedures are billed separately with appropriate modifier reductions, the total work RVW totals 23.40 [14.48 + (7.10 x 50%) + (10.74 x 50%)]. The RUC agreed with the consensus panel and concurred that the 75th percentile intra-service time and work RVU appropriately accounted for and appropriately valued the physician work involved. The reference service, which is not an analogous service includes only 90 minutes of intra-service time, opposed to the 120 minutes recommended by the specialties and only 10 minutes of pre-service time versus 65 minutes in the surveyed code. The resulting difference in total time is 339 minutes versus 261 minutes within the reference service. The intensity and complexity measures also reveal that the survey respondents believed that 284XX was much more intense that the reference service.

The RUC did note that the single 99231 hospital visit included duplicative work accounted for in the full 99238 discharge management visit within the code's global period. The RUC removed this visit, leaving one 99238, two 99212, and three 99213 visits within the global period. The RUC recommends physician pre-service time of 65 minutes, intra-service time of 120 minutes and immediate post-service time of 15 minutes for 28446. **The RUC recommends the specialty society survey 75th percentile work RVU of 17.50 for 28446.**

Practice Expense
The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

Arthroscopic Biceps Tenodesis (Tab 17)
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Beach, MD, AAOS

In February 2007, the CPT Editorial Panel created a new Category I CPT code, 29828, *Arthroscopy, shoulder, surgical; capsulorrhaphy; biceps tendonesis*, to describe a closed surgical process utilizing arthroscopic technique for biceps tendonesis. Prior to the introduction of this new coding, only open biceps

tendonesis was described in CPT, despite increasing utilization of the closed arthroscopic technique.

The RUC reviewed the specialty societies' survey results describing the physician work for CPT code 29828. The RUC also reviewed the surveyed service in comparison to the key reference service, CPT code 29807, *Arthroscopy, shoulder, surgical; repair of SLAP lesion* (work RVU = 14.48). While the survey data were reliable, the specialty societies and the RUC agreed that the survey median work RVU was too high, as the surveyed service requires less time and is not more intense than the reference service. In comparison to the key reference service, the surveyed service contains slightly less intra-service and post-service time (intra = 75 and 20 minutes compared to post = 90 and 30 minutes, respectively) while the intensity and complexity measures between the two services were very similar in all categories assessed. The RUC concurred that the 25th percentile of the survey data (13.00 work RVUs) was more appropriate and accurately reflected the time and intensity involved in performing the service, especially when compared to the key reference service, code 29807. **The RUC recommends the survey's 25th percentile work RVU of 13.00 for code 29828.**

Practice Expense
The RUC recommends the specialty societies' recommended inputs for these facility only procedures as they are standard 090 day global inputs.

New Technology
Because the service was developed relatively recently and at the request of the specialty society, **the RUC recommends that code 29828 be added to the New Technology list**

<u>Subtalar Arthroscopy (Tab 18)</u>
R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), William Beach, MD, AAOS, Lloyd Smith , DPM, American Podiatric Medical Association (APMA)

In February 2007, the CPT Editorial Panel created four new Category I CPT codes to describe procedures not previously included in CPT for arthroscopy of subtalar joints.

29904
The RUC reviewed the specialty societies' survey results and presentation for 29904, *Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body*. The RUC considered the surveyed code in comparison to the key reference service selected by two-thirds of the survey respondents, 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47). The RUC noted that the intra-service times are identical (60 minutes), however, the intensity and

complexity required to perform the surveyed code is less than the reference service. Particularly, the reference service requires slightly greater mental effort and judgment as well as greater psychological stress. The RUC agreed with the specialty societies, that in light of this comparison, the survey median work RVU of 9.47 was too high. The RUC concurred that the 25th percentile work RVU of 8.50 was appropriate and was an accurate valuation of the work involved to perform the service. **The RUC recommends the 25th percentile work RVU 8.50 for code 29904.**

29905

The RUC reviewed the specialty societies' survey results and presentation for 29905, *Arthroscopy, subtalar joint, surgical; with synovectomy*. The RUC considered the surveyed code in comparison to the key reference service 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47). The RUC noted that the intra-service times are identical (60 minutes), however, the intensity and complexity required to perform the surveyed code is only slightly less than the reference service. Particularly, the reference service requires slightly greater mental effort and judgment as well as greater psychological stress. The RUC agreed with the specialty societies, that in light of this comparison, the survey median work RVU of 10.00 was too high. The RUC concurred that the 25th percentile work RVU of 9.00 was appropriate and was an accurate valuation of the work involved to perform the service and maintained proper rank order within the family of services. **The RUC recommends the 25th percentile work RVU 9.00 for code 29905.**

29906

The RUC reviewed the specialty societies' survey results and presentation for 29906, *Arthroscopy, subtalar joint, surgical; with debridement*. The RUC considered the surveyed code in comparison to the key reference service 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47). The RUC noted that the intra-service times are identical (60 minutes), however, the intensity and complexity required to perform the surveyed code is nearly identical to the reference service. As such, the RUC agreed with the specialty societies, that in light of the close comparison and relativity with the reference service, the survey median work RVU of 10.00 was too high. The RUC concurred that the 25th percentile work RVU of 9.47, identical to the reference service, was appropriate as well as an accurate valuation of the work involved to perform the service and maintained proper rank order within the family of services. **The RUC recommends the 25th percentile work RVU 9.47 for code 29906.**

29907

The RUC reviewed the specialty societies' survey results and presentation for 29907, *Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis*. The RUC considered the surveyed code in comparison to the key reference service 29899,

Arthroscopy Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis (work RVU = 15.21). The RUC noted that the reference service contains significantly more intra-service time than the surveyed code (120 minutes versus 90 minutes). In addition, the pre- and post-service times are slightly greater in the reference code as compared to the surveyed code (pre = 75 versus 65 minutes and post = 30 versus 15 minutes, respectively). However, the intensity and complexity required to perform the surveyed code is very comparable to the reference service. The surveyed code requires greater technical skill, physical effort, psychological stress, and greater intensity/complexity in pre-, intra-, and post-service times compared to the reference service. Given the similarities in intensity and complexity, but differences in time, the RUC agreed that the survey median of 14.00 work RVUs was too high and believed that the 25th percentile work RVU of 12.00 appropriately accounted for the physician work involved in the service. The RUC did not agree with the number of hospital visits included within the service's global period. Because the service is typically performed without an extensive hospital stay, a 99231 visit in addition to the full 99238 discharge day management visit was excessive. The specialty agreed and the RUC recommended removing the 99231 hospital visit. **The RUC recommends the 25th percentile work RVU 12.00 for code 29907.**

Practice Expense
The RUC recommends the specialty societies' recommended inputs for these facility-only procedures as they are standard 090 day global inputs. No practice expense is recommended in the non-facility setting. The attached PE spreadsheet reflects these issues.

Application of Cranial Tongs (Tab 19)
Frederick Boop, MD, American Association of Neurological Surgeons/ Congress of Neurological Surgeons (AANS/CNS), R. Dale Blasier, MD, American Association of Orthopaedic Surgeons (AAOS), Claire Tibiletti, MD North American Spine Society (NASS)

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* be removed from the modifier -51 exempt list. The Workgroup asked specialty societies to review the list and bring back any code they felt should be retained on the list. At the February 2007 CPT meeting the specialty societies asked to retain 20660 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 20660 to the RUC. Code 20660 had never been surveyed nor discussed at the RUC previously. The RUC understood that it was tasked with considering whether 20660 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 20660.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service did have significant time in the pre-service and post service periods which disqualifies 20660 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

Based on the above criteria, the RUC concurs with the CPT Editorial Panel that 20660 be removed from the Modifier -51 Exempt List.

The RUC considered whether there is compelling evidence for re-valuation of 20660. The specialty society explained that when 20660 is performed as part of a surgical procedure to stabilize the neck, that it is bundled with that surgical code. The RUC understood that it was considering the service described by 20660 only when it is done as a stand-alone code. The RUC noted that it is often performed with an E/M service. The RUC agreed that removal from the -51 exempt modifier list was an adequate reason for re-valuation.

The RUC reviewed the specialties' survey results in order to value the service. Code 20660 was originally valued by Harvard and recommended to CMS as a 090 day global service in 1992 with a work RVU of 3.81. In 1993, CMS dropped the value to 2.57 and changed the service to a 000 day global, and placed 20660 on the -51 Modifier Exempt list.

The RUC agreed that survey respondents mis-classified some intra-service time for 20660. Specifically, physician work of positioning the patient was classified by survey respondents as pre-service. The RUC and specialties agreed that due to the critical nature of injury in these patients (unstable cervical fracture), the physician's intra- work begins when he personally stabilizes the neck while transferring the patient to the traction bed. All participants agreed to reallocate 15 minutes of pre-service positioning time to the intra-service period, and eliminate

10 minutes of pre-service evaluation time. All changes of physician time are shown in the table below and were used in the following crosswalks.

Physician Time	Pre-Eval	Pre-Positioning	Pre-Scrub, Dress, Wait	Intra-Service	Immediate Post	Total Physician Time
Original Rec	20	0	15	47	19	101
RUC Rec	**20**	**0**	**10**	**30**	**30**	**90**

The RUC compared the service to MPC listed code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (work RVU = 3.69, 000 global). CPT Code 20660 and 19103 have the same amount of intra-service time, 30 minutes although CPT code 20660 requires a higher intensity to complete. Based on the specialties' survey results, an enhanced understanding of the service resulting in a reallocation of physician time, and comparisons of similar services across specialties, the RUC believed the specialty societies survey median of 4.00 work RVUs was appropriate. **The RUC recommends a relative work value of 4.00 RVUs for code 20660.**

Practice Expense
After further discussion with the specialty societies, it became clear that 20660 is not performed in the non-facility setting. **The RUC recommends no practice expense inputs in the facility and non-facility settings.**

Insert Emergency Airway (Tab 20)
Tripti Kataria, MD, MPH, American Society of Anesthesiologists (ASA), James Perri, MD, American College of Emergency Physicians (ACEP)

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 31500 *Intubation, endotracheal, emergency procedure* be removed from the modifier -51 exempt list. The Workgroup asked specialty societies to review the list and bring back any code they felt should be retained on the list. At the February 2007 CPT meeting the specialty societies asked to retain 31500 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 31500 to the RUC. Code 31500 had never been surveyed nor discussed at the RUC previously. The RUC understands that it is tasked with considering whether 31500 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 31500.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending

modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service had significant time in the pre-service and post service periods which would disqualify 31500 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

After significant discussion, the RUC determined that the specialty society recommended pre-service time did not accurately reflect the service and decreased it from 9 minutes to 4 minutes, while retaining the post-operative time at 10 minutes. **Due to a detailed review of the pre-service and post-service time to ensure no duplication with other service performed on the same date, the RUC recommends that 31500 be retained on the Modifier -51 Exempt List.**

As the RUC works under the presumption that all services on the RBRVS are correctly valued unless evidence is produced to revalue, the specialty society provided compelling evidence to support its recommendation of 2.55 RVUs, which is an increase over the existing value of 31500, 2.33 RVUs. The RUC reviewed this compelling evidence and did not agree with the specialty that there had been changes in the techniques and methods of providing endotracheal intubation. **Therefore, the RUC recommends the new physician times, 4 minutes of pre-service time, 5 minutes of intra-service time and 10 minutes of post-service time associated with 31500 and that the existing value of 2.33 work RVUs be retained for this procedure.**

Practice Expense:
The RUC recommends that the practice expense inputs be retained for this procedure, which is no practice expense inputs in the facility or non-facility setting.

<u>Arterial Catheterization (Tab 21)</u>
Tripti Kataria, MD, MPH, American Society of Anesthesiologists (ASA)

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* be removed from

the modifier -51 exempt list. The Workgroup asked specialty societies to review the list and bring back any code they determined should be retained on the list. At the February 2007 CPT meeting the specialty societies asked to retain 36620 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 36620 to the RUC. Code 36620 had never been surveyed nor discussed at the RUC previously. The RUC understands that it is tasked with considering whether 36620 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 36620.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service did have significant time in the pre-service and post service periods which would disqualify 36620 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal number of post-operative visits associated with the valuations of the procedures on this list."

After significant discussion, the RUC determined that the specialty society recommended pre-service time did not accurately reflect the service and decreased it from 13 minutes to 7 minutes, while retaining the post-operative time at 5 minutes. **Due to this detailed review of the pre-service and post-service time to ensure no duplication with other services reported on the same date, the RUC recommends that 36620 be retained on the Modifier -51 Exempt List.**

As the RUC works under the presumption that all services on the RBRVS are correctly valued unless evidence is produced to re-value, the specialty society provided compelling evidence to support its recommendation of 1.50 work RVUs, which is an increase over the existing value of 36620, 1.15 work RVUs. The RUC reviewed this compelling evidence and did not agree with the specialty that there was evidence that incorrect assumptions were made in the previous evaluation of

this service. **Therefore, the RUC recommends that the new times, 7 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time be associated with 36620 and that the existing value of 1.15 work RVUs be retained for this procedure.**

Practice Expense:
The RUC recommends that the practice expense inputs be retained for this procedure, which is zero direct PE inputs.

Insertion and Placement of Heart Catheter (Tab 22)
Tripti Kataria, MD, MPH, American Society of Anesthesiologists (ASA)

In October 2006, the CPT Editorial Panel CPT Modifier Workgroup recommended 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* be removed from the modifier -51 exempt list. The Workgroup asked specialty societies to review the list and bring back any code they determined should be retained on the list. At the February 2007 CPT meeting the specialty societies asked to retain 93503 on the -51 Modifier exempt list. The CPT Modifier Workgroup forwarded 93503 to the RUC. Code 93503 had never been surveyed nor discussed at the RUC previously. The RUC understands that it is tasked with considering whether 93503 should be retained on the modifier -51 exempt list. If so, then support for this position is needed and the RUC must develop a work RVU recommendation consistent with the modifier -51 exempt payment policy. If not, then the RUC should determine whether there is compelling evidence for revaluation of 93503.

FROM THE CPT MANUAL: "Modifier -51: Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service listed may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes."

The RUC heard a full description of the service and the history of its value. The specialty societies and the RUC understood that the service did have significant time in the pre-service and post-service periods which would disqualify 93503 from the -51 Modifier exempt list (according to the CPT's criteria for inclusion on the list).

FROM CPT: MODIFIER -51 EXEMPTION – INCLUSION/EXCLUSION CRITERIA
"#3 Minimal Amount of Pre-and Post-Service Time Relative to Intra-Service Time and Minimal Number of Visits. As these procedures are usually performed with other procedures, there should be a minimal amount of pre-and post-service time relative to the procedure's intra-service time and there should be a minimal

number of post-operative visits associated with the valuations of the procedures on this list."

After significant discussion, the RUC determined that specialty society recommended pre-service time did not accurately reflect the service and decreased it from 20 minutes to 12 minutes, while retaining the post-operative time at 10 minutes. **Due to this detailed review of the pre-service and post-service time to ensure no duplication with other services reported on the same date, the RUC recommends that 93503 be retained on the Modifier -51 Exempt List.**

The specialty reviewed the survey results for this procedure and determined that the survey results support the existing value of the code at 2.91 work RVUs. The current value of the code, falls very close to the survey median of 3.00 RVUs. In addition, as the surveyed code's intensity and complexity measures are higher than that of the reference code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (Work RVU=2.50), the current value was believed to be appropriate. **Therefore, the RUC recommends that the new times, 12 minutes of pre-service time, 15 minutes of intra-service time and 10 minutes of post-service time, be associated with 93503 and that the existing value of 2.91 work RVUs be retained for this procedure.**

Practice Expense:
The RUC recommends that the practice expense inputs be retained for this procedure, which is zero PE direct inputs.

Add-on Maze Procedures (Tab 23)
Kirk Kanter, MD, Society of Thoracic Surgeons (STS)

In 2006, the Society of Thoracic Surgeons (STS) brought forward new codes for the Maze procedures to account for the new technology and various techniques to perform Maze procedures. These codes, 33254 *Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)* (Work RVU=23.58), 33255 *Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass* (Work RVU=28.91), and 33256 *Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass* (Work RVU=34.77) were approved by CPT for the 2007 cycle and replaced code 33253 *Operative incisions and reconstruction of atria for treatment of atrial fibrillation or atrial flutter (eg, maze procedure)* (work RVU=31.01). During the valuation process at the RUC, it was determined that a significant number of these procedures were performed in conjunction with other cardiac procedures. As a result, the RUC determined that the new open codes for 2007 should not be reported with other cardiac procedures and asked CPT to add verbiage to the guidelines for the open Maze codes indicating that they should not be reported in addition to other cardiac procedures and to report this circumstance, the unlisted cardiac procedure code (33999) should be reported.

The RUC suggested that add-on codes would allow appropriate valuation of these services. The CPT Editorial Panel, therefore, created three new add-on Maze codes to allow for reporting of these services with other cardiac procedures.

The specialty society utilized a standard RUC survey instrument and received survey responses from 70 thoracic surgeons. The survey data was reviewed by a consensus committee and was further supported by data from the STS Database. All of this data supported the notion made by the specialty that the patient in which these procedures are performed on, is a very intense, complicated patient with probable comorbities including congestive heart failure and cerebrovascular disease as these services would be performed in addition to other cardiac procedures including 33533 *Coronary artery bypass, using arterial graft(s); single arterial graft* (Work RVU=33.64). The specialty society explained that the complexity/severity of this patient justifies the pre-service and post-service times as well as post-operative visits not typically associated with other ZZZ global procedures and further justified that during the 2005 Five-Year Review precedents had been set that other ZZZ global codes within the cardiothoracic families received these additional times and visits. Additionally, the RUC had some concern that as these procedures are ZZZ global procedures, typically there would not be a discharge day-management procedure associated with them. The specialty society explained that the patients who would receive these procedures are very complex as they are receiving the add-on maze procedure in addition to another cardiac procedure. The additional half of the 99238 discharge day management procedure associated with these add-on maze procedures is a proxy as when a Maze procedure is performed with the base cardiac code, a level 99239 discharge day management procedure, would be typical for these patients. A RUC member did express concern regarding whether the CABG codes and other thoracic surgery services in the 2005 Five-Year Review included the Maze procedures in STS database time. The STS stated that the time in the STS database, as used in the 2005 Five-Year Review, only includes time for services where a single procedure was performed and would not reflect the additional time needed to perform the add-on Maze procedures.

33257 *Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure), (List separately in addition to the code for the primary procedure)*
The specialty society made revisions to the pre-service and post-service time, reducing both from 30 minutes to 15 minutes to more accurately reflect the services provided during these periods of time. The RUC reviewed 33257 in comparison to its reference code 33518 *Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (List separately in addition to code for arterial graft)* (Work RVU=7.93). The RUC noted that the total service time for 332570 was longer than the reference code, 180.30 minutes and 112.60 minutes. Further, the RUC noted that the surveyed code is a more complex procedure to perform in comparison to the reference code. Therefore, the RUC recommends 9.63 work RVUs, the survey's 75th percentile, as this value appropriately places this service in

comparison to the reference code. The RUC further noted that under current payment policy, when 33254, the stand- alone equivalent of this code, is performed with another cardiac procedure, it would be subject to the multiple procedure reduction and would be decreased by 50 percent, resulting in a value of 11.79 work RVUs which is substantially higher in value than the proposed recommended RVU of the add-on procedure. **The RUC recommends 9.63 work RVUs for 33257.**

33258 *Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass, (List separately in addition to the code for the primary procedure)*

The specialty society made revisions to the pre-service and post-service time, reducing both from 30 minutes to 15 minutes to more accurately reflect the services provided during these periods of time. The RUC reviewed 33258 in comparison to its reference code 33519 *Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (List separately in addition to code for arterial graft)* (Work RVU=10.49). The RUC noted that the total service time for 33258 was longer than the reference code, 190.30 minutes and 139.80 minutes. Further, the RUC noted that the surveyed code is a more complex procedure to perform in comparison to the reference code. Therefore, the RUC recommends 11.00 work RVUs, the survey's 75th percentile, as this value appropriately places this service in comparison to the reference code. The RUC further noted that under current payment policy, when 33255, the stand- alone equivalent of this code, is performed with another cardiac procedure, it would be subject to the multiple procedure reduction and would be decreased by 50 percent, resulting in a value of 14.46 work RVUs which is substantially higher in value than the proposed recommended RVU of the add-on procedure. **The RUC recommends 11.00 work RVUs for 33258.**

33259 *Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass, (List separately in addition to the code for the primary procedure)*

The specialty society made revisions to the pre-service and post-service time, reducing both from 30 minutes to 15 minutes to more accurately reflect the services provided during these periods of time. The RUC reviewed 33259 in comparison to its reference code 33522 *Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (List separately in addition to code for arterial graft)* (Work RVU=14.14). The RUC noted that the total service time for 33259 was comparable to the reference code, 222.70 minutes and 174.45 minutes. However, the RUC noted that the surveyed code requires similar complexity in comparison to the reference code. Therefore, the RUC recommends 14.14 work RVUs, the survey's 75th percentile, as this value appropriately places this service in comparison to the reference code. The RUC further noted that under current payment policy, when 33256, the stand- alone equivalent of this code, is performed

with another cardiac procedure, it would be subject to the multiple procedure reduction and would be decreased by 50 percent, resulting in a value of 17.39 work RVUs which is substantially higher in value than the proposed recommended RVU of the add-on procedure. **The RUC recommends 14.14 work RVUs for 33259.**

The RUC notes that its original assertion that Maze procedures performed in conjunction with other cardiac services be valued less than the 50% multiple surgery reduction is maintained with these recommendations.

Practice Expense:
The RUC recommends the standard cardiothoracic surgery 090 day global practice expense inputs package for 33257, 33258 and 33259.

New Technology:
The RUC recommends that 33257, 33258 and 33259 be added to the new technology list as this procedure utilizes new techniques.

Valve Sparing Aortic Annulus Reconstruction (Tab 24)
Kirk Kanter, MD, Society of Thoracic Surgeons (STS)

The CPT Editorial Panel created a new CPT code to report performance of root reconstruction in which the aortic valve is preserved and the aortic annulus is remodeled. The current codes represent different work from that involved in a valve sparing aortic annulus reconstruction. Changes in the patient population as well as changes in technology and techniques have allowed surgeons to perform a root reconstruction preserving the aortic valve and remodeling the aortic annulus, when indicated in a certain population of patients.

The RUC reviewed CPT code 33864 *Ascending aorta graft, with cardiopulmonary bypass with valve suspension; with coronary reconstruction and valve sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)* in comparison to its reference code, 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (Work RVU=58.71). The RUC noted that the intra-service time associated with the surveyed code is greater than the intra-service time associated with the reference code, 300 minutes and 287 minutes, respectively. Additionally, the RUC compared the intensity/complexity measures of the surveyed code to the reference code and noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort to perform than the reference code. Therefore, because the surveyed code has more intra-service time and greater intensity/complexity than the reference code, the RUC recommends the median survey value, 60.00 RVUs. **The RUC recommends 60.00 RVUs for 33864.**

Practice Expense:
The RUC recommends the standard 090 day global practice expense inputs package for 33864.

New Technology:
The RUC recommends that 33864 be added to the new technology list as this procedure utilizes new techniques.

Wireless Pressure Sensor Implantation (Tab 25)
Gary Seabrook, MD, Society for Vascular Surgery (SVS), David Han, MD, SVS, Jonathan W. Berlin, MD, American College of Radiology (ACR), Geraldine McGinty, MD, ACR, Robert Vogelzang, MD Society for Interventional Radiology (SIR)

The CPT Editorial Panel replaced two Category III codes with two new Category I codes to describe the placement and subsequent monitoring of an implanted wireless pressure sensor located inside the body, within an aneurysm sac, but outside an endovascular graft as the service is currently performed 1,000 times per year and is likely to increase in utilization rapidly.

34806
The RUC reviewed the survey data for code 34806 *Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration and collection of pressure data.* The RUC compared 34806 to the key reference code indicated by the survey respondents, 34808 *Endovascular placement of iliac artery occlusion device* (Work RVU=4.12). The specialty societies indicated and the RUC agreed that the key reference service requires two times more physician work than 34806. The reference service has a total physician time of 60 minutes, however the new service requires a total of 35 minutes to complete (10 minutes pre-service time and 25 minutes intra-service time). The add-on reference service has zero pre- and post-time, however, the new service requires 10 minutes of pre-service evaluation time because sensor implantation is an independent and separate service that requires discussion with the patient and family during final preparations on the date of surgery as the physician reviews issues surrounding informed consent. Additionally, the surgeon/intervetionalist needs to ensure that the appropriate devices are present in the operating room and that the "Interrogator" (instrument that excites the sensor and records data from implanted device) is present and available. The RUC agreed that pre-service time of 10 minutes, intra-service time of 25 minutes is appropriate for code 34806. **The RUC recommends a work RVU of 2.06 for code 34806.**

93982
The RUC discussed CPT code 93982 *Non-invasive physiologic study of implanted wireless pressure sensor in aneurismal sac following endovascular repair,*

complete study including recording, analysis of pressure and waveform tracings, interpretation and report, and clarified that the service would have both a professional component (PC) and technical component (TC). The RUC then reviewed the specialty society survey results regarding physician work involved in the service. The RUC agreed with the specialty society recommendations to reduce the pre- and post-service times to two minutes each, because based on the associated work the pre- and post-service time is minimal. Further, the RUC agreed with the specialty society and determined that the 25th percentile survey work RVU, 0.30, was appropriate and maintained proper rank order in relation to the key reference service, CPT code 93731 *Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming*, (Work RVU = 0.45). Additionally, the reference service has slightly higher pre-, intra-, and post-service times (pre = 5 minutes, intra = 15 minutes, post = 5 minutes) and nearly identical intensity/complexity measures. The RUC agreed that pre-service time of 2 minutes, intra-service time of 10 minutes, and post-service time of 2 minutes is appropriate for code 93982. **The RUC recommends a work RVU of 0.30 for code 93982.**

Practice Expense
34806
The RUC determined and recommends that no direct practice expense inputs are required for code 34806.

93982
The RUC discussed the practice expenses involved in the technical component of this service performed in the non-facility setting. The RUC determined that the pre-service clinical activity of retrieving and reviewing patient records and previous studies was more appropriately accounted for in the intra-service period and performed by the technologist. Therefore, the pre-service time was reduced from three minutes to zero. The RUC also noted that the study takes place in a room that does not require preparation of the room, equipment or supplies and removed the two minutes allotted. The assist physician time denoted as 15 minutes was verified by the specialty societies and the RUC agreed that the time was appropriate. The intra-service time is not specifically spent assisting the physician, but rather includes the time for the technologist to perform the test. The specialty societies also discussed the other service period time and the RUC determined that time was appropriately allotted to greet the patient, obtain vitals, obtain consent, set-up equipment, and position the patient. **The RUC recommends the direct practice expense inputs as amended for code 93982.**

New Technology
As these codes were previously reported using the Category III codes, the RUC recommends that codes 34806 and 93982 be added to the New Technology List so that these services can be closely monitored for any changes in utilization.

Brachial-Ulnar Bypass Graft (Tab 26)
Gary Seabrook, MD, Society for Vascular Surgery (SVS), Matthew Sideman, MD, SVS, Robert Zwolak, MD, SVS

The CPT Editorial Panel created a new code to describe upper extremity bypass grafts performed to prevent arm amputation in a patient with very advanced arterial occlusive disease and gangrene of the digits.

The RUC reviewed the survey results for code 35523 *Bypass graft, with vein; common carotid-ipsilateral internal carotid brachial-ulnar or –radial* compared to the key reference service, 35512 *Bypass graft, with vein; subclavian-brachial* (Work RVU=23.79, 68 minutes pre-service, 180 minutes intra-service and 30 minutes immediate post-service time). The specialty society indicated that this reference service is a similar procedure performed in the shoulder/upper arm region. The RUC agreed that the mental effort, technical skill and psychological stress involved when performing 35523 were comparable to 35512. The RUC determined that the survey median work RVU of 24.00 placed 35523 in the proper rank order compared to 35512. The RUC then compared the pre-, intra- and immediate post service times (75 minutes, 180 minutes and 30 minutes) for 35523 to the reference service and determined that the specialty society recommended intra-service and immediate post-service physician times were the same. The specialty society recommended pre-service time for 35523 is 7 more minutes than the reference code. The RUC determined that additional positioning time is needed to accurately position the arm and gangrenous fingertips and well as extend the shoulder without compromising neurovascular structures.

The RUC reviewed the post-operative visits and determined that code 35523 requires an additional 99212 visit than reference code 35512. The RUC determined that the additional 99212 visit is necessary because of the required attention to wound healing, patency of the bypass graft, reperfusion of the hand, return to outpatient medical balance and the care of the reperfused fingers with gangrenous fingertips. The RUC agreed that 75 minutes pre-service, 180 minutes intra-service and 30 minutes immediate post-service physician time is appropriate for 35523. The RUC recommends the following post-operative visits for code 355X2: two 99232, one 99231, one 99238, two 99212 and two 99213 visits. **The RUC recommends the survey median work RVU of 24.00 for 35523.**

Practice Expense
The RUC recommends the standard 090 day global direct practice expense inputs as attached.

Head and Neck Interstitial Brachytherapy Needle or Catheter Placement (Tab 27)
Najeeb Mohideen, MD, Michael Kuettel, MD, MBA, PhD, David Beyer, MD, American Society of Therapeutic Radiation Oncology (ASTRO)

In February 2007, the CPT Editorial Panel created a new CPT code to describe surgical placement of brachytherapy needles or catheters in the head and/or neck region.

The RUC reviewed the survey results from 50 radiation oncologists for new CPT code 41019 *Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application* and the specialty's key reference code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* (work RVU 13.31, 090 day global). The RUC concurred that the survey respondents over estimated the physician work for this new 000 day global procedure, and the physician time appeared to be overstated in the pre-service time period.

The RUC determined that new code 41019 requires the same physician work, time, and intensity as code 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* (work RVU = 8.84). In addition, the RUC believed that the pre-service physician time should be reduced by a total of 25 minutes, to reflect the typical patient evaluation and positioning time. The RUC determined that the typical patient would require pre-service evaluation time of 30 minutes, positioning of 10 minutes, and 15 minutes for scrub, dress, and wait, intra-service time of 90 minutes and an immediate post service time of 30 minutes, for code 41019. **The RUC recommends a physician work relative value of 8.84 for CPT code 41019.**

Practice Expense
The RUC recommends no direct practice expense inputs in the non-facility setting for this facility only service. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service.

Peritoneal Tumor Ablation (Tab 28)
Charles Mabry, MD, FACS, American College of Surgeons (ACS), Christopher Senkowski, MD, ACS, George Hill, MD, American Society of Reproductive Medicine (ASRM)

In April 2006, the RUC reviewed new codes 58957 *Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;* (work RVU = 26.06) and 58958 *Resection (tumor debulking) of recurrent ovarian, tubal,*

primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy (work RVU = 29.06). Codes 58957 and 58958 had been split out from CPT codes 49200 *Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas;*(work RVU = 10.94) and 49201 *Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive* (work RVU = 15.67). The RUC determined that 49200 and 49201 should be reviewed for potential work neutrality, but first requested a review by general surgery. The RUC asked general surgery to survey code 49200 and 49201 for presentation in October 2006.

General surgery attempted to survey the codes for the October 2006 RUC meeting, however it was determined that the vignettes and CPT descriptors were confusing to the survey participants. The specialty indicated that they needed to first address new coding for these services, resulting in the replacement of 49200 and 49201 with three new codes. When these codes were initially created and valued, during the Harvard review, the typical patient was described as on one who had three lymphatic cysts removed. Today lymphatic cysts are treated by less evasive means. The typical patient today has a tumor which is removed openly. The specialty indicated that they needed to accurately describe the codes in CPT. The RUC agreed that coding changes were needed prior to the survey, and in February 2007 the CPT Editorial Panel deleted codes 49200 and 49201 and replaced them with three new codes to report resection and debulking of specific recurrent malignancies. The RUC agreed with the specialty that the typical patient had changed so that the current codes could not describe the procedures being performed. The RUC determined that there was compelling evidence that these services were never described or valued properly.

For the April 2007 RUC meeting, the ACS independently surveyed the three new codes (49203, 49204, 49205) while the ACOG independently surveyed 49203 and 49204. The RUC determined that the vignette used by the American College of Obstetricians and Gynecologists (ACOG) would not be used as it was not vetted through the standard CPT Editorial Panel Process.

49203

The committee reviewed the ACS survey data for 49203 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less* and compared it to the reference code as selected by the ACS survey respondents, 44140 *Colectomy, partial; with anastomosis* (Work RVU=22.46). The surveyed code has significantly less intra-service time as compared to the reference code, 120 minutes and 150 minutes, respectively. Additionally, the RUC determined that the surveyed code is a less intensive procedure to perform than its reference code. Therefore, because the surveyed

code has less intra-service time and is a less intensive procedure to perform in comparison to the reference code, the RUC recommends the 25th percentile of the survey data, 20.00 work RVUs. **The RUC recommends a physician work relative value of 20.00 RVUs for CPT code 49203.**

49204

The committee reviewed the ACS survey data for 49204 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less; largest tumor 5.1 to 10.0 cm diameter* and compared it to multi-specialty points of comparison reference code, 44140 *Colectomy, partial; with anastomosis* (Work RVU=22.46). The committee reviewed all of the surveyed times for this procedure and determined that the post-operative visits of the surveyed code should mirror the post-operative visits of the reference code, as the distribution of the reference code's post-operative visits seemed to better reflect the post-operative care of the surveyed code. Therefore, the committee recommends that one 99232 hospital visit be transitioned to a 99231 hospital visit, resulting in one 99232 hospital visit and five 99231 hospital visits for the surveyed code. Further, the committee reviewed the other service times associated with this code and noted that the surveyed code has more intra-service time associated with it than the reference code (160 minutes and 150 minutes, respectively) and that the surveyed code has more pre-service time than the reference code (81 minutes and 60 minutes, respectively). Additionally, the RUC determined that the surveyed code is a more intensive procedure to perform than the reference code. Therefore, because the surveyed code has more pre-service and intra-service time and is a more intensive procedure to perform than the reference code, the RUC recommends the median of the survey data, 26.00 work RVUs. **The RUC recommends a physician work relative value of 26.00 RVUs for CPT code 49204.**

49205

The committee reviewed the ACS survey data for 49205 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, one or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less; largest tumor greater than 10.0 cm diameter* and compared it to two reference codes as selected by the ACS respondents, 43633 *Gastrectomy, partial, distal; with Roux-en-Y reconstruction* (Work RVU=33.01) and 58957 *Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;* (Work RVU=26.06). The committee used these two codes as anchors to develop work RVU recommendations for 49205. The committee compared the total service times of all three codes and noted that the total service time for the surveyed code fell between the two reference codes (Total Time, 43633: 740 minutes; 49205: 645 minutes and 58957: 552 minutes). Further, the committee noted that the intensity of performing the surveyed code fell between the two reference codes. Therefore, because the surveyed code fell between the

two reference codes in times and intensities, the RUC recommends the median survey value, 30.00 work RVUs for code 49205. **The RUC recommends a physician work relative value of 30.00 RVUs for CPT code 49205.**

Practice Expense
The RUC recommends no direct practice expense inputs in the non-facility setting for these facility only services. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service based on the 90 day global RUC standards.

G-, J-, G-J and C-Tube Procedures (Tab 29)
Robert Vogelzang, MD Society for Interventional Radiology (SIR), Sean Tutton, MD, Geraldine McGinty, MD, American College of Radiology (ACR), Jonathan W. Berlin, MD

The CPT Editorial Panel created nine new codes and revised one current code to describe the array of percutaneous gastrostomy, jejunostomy, gastro-jejunostomy or cecostomy tube procedures and services including initial placement, conversion, replacement and removal, as well as mechanical removal of obstructive material and injection of contrast for radiological evaluation of a tube.

The RUC reviewed 49440-49465 and 43760. The RUC recognized that the survey response rates were low, ranging from 15-20 respondents for 49440-49465. The RUC noted that these procedures are frequently performed and the small number of respondents did not adequately represent these services as performed. **The RUC recommends that the following work RVUs as interim values until the RUC next meeting after the specialty societies have resurveyed and are able to present representative recommendations.** Additionally, code 43760 had a sufficient response rate of 40 respondents, however, since the recommended value is linked to 49450 and the specialty society determined that it should be resurveyed as well.

49440 *Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49440 and compared this service to the key reference code 36558 *Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older* (Work RVU=4.81). The RUC determined that the physician time required to perform 49440 was similar to the reference service. However, the RUC determined that a discharge day management visit was not performed and the associated work RVUs should be extracted. The RUC determined that extracting 1.28 RVUs of the discharge day management (99238) from the survey median RVU of 4.60, would place this service in the proper rank order among other services within this family and across specialties (4.60-1.28=3.32 Work RVU). The RUC also compared this service to codes 44365 *Small intestinal endoscopy, enteroscopy*

beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery (Work RVU=3.31) and 45915 *Removal of fecal impaction or foreign body (separate procedure) under anesthesia* (Work RVU=3.16) and determined that the recommended work RVU places code 49440 in the proper rank order. **The RUC recommends an interim work relative value of 3.32 for code 49440.**

49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The RUC reviewed the survey data for 49441 and determined that the survey respondents overestimated the pre-service scrub, dress, and wait time, therefore the RUC reduced this time to 10 minutes. The RUC also determined that a discharge day management visit was not performed and the associated work RVUs should be extracted. The RUC determined that extracting 1.28 RVUs of the discharge day management (99238) from the survey median RVU of 7.00 would place this service in the proper rank order among other services within this family and across specialties (7.00-1.28=5.72 Work RVU). The RUC also compared this service to codes 45382 *Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (Work RVU=5.68) and 49421 *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent* (Work RVU=5.87) and determined that the recommended work RVU places code 49441 in the proper rank order. **The RUC recommends an interim work relative value of 5.72 for code 49441.**

49442 *Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*

The RUC reviewed the survey data for 49442 and determined that the specialty recommendation of the 75% percentile survey work RVU supported by a building block methodology was not representative of this procedure. The median survey work RVU of 5.15 was used as a starting point for valuing 49442. The RUC determined that a discharge day management visit was not performed and the associated work RVUs should be extracted. In addition, the RUC and specialty societies agreed only one hospital post-operative visit (99231) was typical rather than two, as indicated from the survey results. The RUC determined that extracting 1.28 RVUs of the discharge day management (99238) from the survey median RVU of 5.15, would place this service in the proper rank order among other services within this family and across specialties (5.15-1.28=3.87 Work RVU). The RUC also compared this service to code 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (Work RVU = 3.99) and determined that in relation to this service, code 49442 would be properly valued at 3.87 RVUs. **The RUC recommends an interim work relative value of 3.87 for code 49442.**

49446 *Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49446 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on a building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49446:
45345 *Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)* (Work RVU = 2.92)
31623 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with brushing or protected brushings* (Work RVU = 2.88)
52007 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis* (Work RVU = 3.02). **The RUC recommends an interim relative work value of 2.94 for code 484X4.**

49450 *Replacement gastrostomy or cecostomy (or other colonic) tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49450 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on a building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49450:
36584 *Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access* (Work RVU = 1.20). **The RUC recommends an interim relative work value of 1.14 for code 49450.**

49451 *Replacement duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49451 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents

overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on a building block methodology and comparing the result across specialties The RUC reviewed the following services to ensure proper rank order placement of 49451:
91122 *Anorectal manometry* (Work RVU = 1.77)
57456 *Colposcopy of the cervix including upper/adjacent vagina; with endocervical* curettage (Work RVU = 1.85). **The RUC recommends an interim relative work value of 1.82 for code 49451.**

49452 *Replacement gastro-jejunostomy tube, percutaneous under fluoroscopic guidance including contrast injection(s), image documentation and report*
The RUC reviewed the survey data for 49452 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on a building block methodology and comparing the result across specialties**.** The RUC reviewed the following services to ensure proper rank order placement of 49452:
57460 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix* (Work RVU = 2.83). **The RUC recommends an interim relative work value of 2.81 for code 49452.**

49460 *Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s) if performed, image documentation and report*
The RUC reviewed the survey data for 49460 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on the building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49460:
46608 *Anoscopy; with removal of foreign body* (Work RVU = 1.51)
62311 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic,*

opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) (Work RVU = 1.54). **The RUC recommends an interim relative work value of 1.51 for code 49460.**

49465 *Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report*
The RUC reviewed the survey data for 49465 and agreed with the specialty societies that the survey results in the pre-service and post-service times did not reflect the typical patient. The RUC determined that the survey respondents overestimated some of the physician's time. The RUC recommends adjusting the pre-service and post-service and subtracting the work RVUs associated per unit of time adjusted. Shown on the attached table, are all elements of pre-service time and the immediate post times. The RUC adjusted the physician time and work RVUs based on the building block methodology and comparing the result across specialties. The RUC reviewed the following services to ensure proper rank order placement of 49465: 36598 *Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report* (Work RVU = 0.74). **The RUC recommends an interim relative work value of 0.62 for code 49465.**

43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance*
The RUC reviewed the survey results for 43760 and agreed with the specialty societies the pre-service time did not reflect that this service is typically performed in the outpatient emergency room setting. The RUC decreased the pre-service physician time to reflect the typical site of service. The physician work involved in 43760 was compared to new code 49450 with the revised recommended work RVU of 1.14, which includes fluoroscopic guidance and image documentation. The RUC determined that the surveyed median of 1.15 RVUs should be reduced to reflect the lack of fluoroscopic guidance and image documentation, but also that the service be relative to other cross specialty services. The RUC reviewed the following codes and believed the overall physician work was similar in intensity and complexity, but required less physician time.
99282 *Emergency department visit for the evaluation and management of a patient* (Work RVU = 0.88)

99213 *Office or other outpatient visit for the evaluation and management of an established patient* (Work RVU = 0.92)

The RUC determined that a reduction of 0.24 work RVUs from the survey median of 1.14 reflects the lack of fluoroscopic guidance and documentation and places the service in the correct rank order with other services on the physician payment schedule (1.14-0.24=0.90). In addition, the specialty survey 25th percentile results

indicated a work RVU of 0.95. **The RUC recommends an interim work RVU of 0.90 for code 43760**.

Conscious Sedation
The RUC determined that conscious sedation was only inherent in codes 49440, 49441, 49442 and 49446 but <u>not</u> for any other code in this family. The facilitation committee recommends no conscious sedation components in the practice expense of codes 49450, 49451, 49452, 49460, and 49465.

Practice Expense
The RUC reviewed and accepted the direct practice expense inputs as modified (eg, remove discharge day management).

Adjustments to Time and RVUs

CPT Code	Tracking Code	Original Specialty Rec	Starting Point RVU	RVUs Adjustment Post Operative Visits	Time Adjustment-Eval Time	Time Adjustment-Positioning Time	Time Adjustment -Scrub Dress Wait	Time Adjustment - Immediate Post	RVU Adjustment from Pre and Immed Post	Final Work Recommendation
49440	KK1	4.60	4.60	-1.28	0	0	0	0	0.0000	3.32
49441	KK2	7.00	7.00	-1.28	0	0	0	0	0.0000	5.72
49442	KK3	6.58	5.15	-1.28	0	0	0	0	0.0000	3.87
49446	KK4	3.50	3.50	0.00	-20	1	-3	-5	-0.5619	2.94
49450	KK5	1.50	1.50	0.00	-15	0	-3	0	-0.3603	1.14
49451	KK6	2.20	2.20	0.00	-15	1	-3	-2	-0.3827	1.82
49452	KK7	3.30	3.30	0.00	-20	0	-3	-1	-0.4947	2.81
49460	KK8	2.00	2.00	0.00	-15	-3	-3	-3	-0.4947	1.51
49465	KK9	0.76	0.76	0.00	-5	0	-3	0	-0.1363	0.62
43760	KK10	1.10	1.10	0.00	-5	0	-3	0	0	0.90

Final Physician Time

CPT Code	Tracking Code	Pre Eval Time	Pre Positioning Time	Pre Scrub Dress Wait	Intra Service Time	Immediate Post	Post Op Visit Time	Total Physician Time	Final Work Recommendation
49440	KK1	35	10	10	30	15	36	136	**3.32**
49441	KK2	45	10	12	60	15	36	178	**5.72**
49442	KK3	43	15	12	30	15	43	158	**3.87**
49446	KK4	10	7	7	30	10	0	64	**2.94**
49450	KK5	10	7	7	15	10	0	49	**1.14**
49451	KK6	10	7	7	20	10	0	54	**1.82**
49452	KK7	10	7	7	28	10	0	62	**2.81**
49460	KK8	10	7	7	15	10	0	49	**1.51**
49465	KK9	10	7	7	8	10	0	42	**0.62**
43760	KK10	10	5	2	10	5	0	32	**0.90**

<u>Intra-Abdominal Voiding Pressure (Tab 30)</u>

James Giblin, MD, American Urological Association (AUA), Michael Albo, MD, AUA

The CPT Editorial Panel changed CPT code, 51797, *Voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)*, from a

stand-alone service to an add-on service. The Panel agreed that the service should be an add-on service as it is virtually always performed with CPT code, 51795, *Voiding pressure studies (VP); bladder voiding pressure, any technique*, (work RVU = 1.53). The intra-abdominal voiding pressure is performed after the bladder study during the same session and involves inserting a rectal catheter and performing an additional calculation.

February 2007
The RUC considered the specialty society's recommendations for code 51797. While this service is currently valued at 1.60 work RVUs, when it is performed in combination with code 51795, the service is subject to the multiple procedure reduction of 50% and valued appropriately at 0.80 work RVUs (1.60 x 50% = 0.80). The specialty society has recommended a work RVU of 1.00 based on a survey of 32 urologists. The RUC informed the specialty society that if it wishes to recommend a work RVU different than 0.80, it must provide compelling evidence to do so. The RUC requested that the specialty provide its recommendation and rationale, including compelling evidence for a change, if warranted, at the April 2007 RUC meeting. The RUC did, however, provide a direct practice expense input in February 2007.

April 2007
At the April 2007 RUC meeting, the specialty society accepted the RUC's recommendation to maintain the appropriate value of 0.80 work RVUs for 51797. The society agreed that there was not compelling evidence to review the work and agreed that the service should be valued at 0.80 work RVUs to maintain its present value of 1.60 work RVU x 50% multiple procedure reduction (0.80). **The RUC recommends a work RVU of 0.80 for code 51797 consistent with its current valuation accounting for the multiple procedure reduction.**

Practice Expense
The RUC recommends the non-facility practice inputs as amended for this ZZZ procedure.

<u>Pelvic Interstitial Brachytherapy Needle or Catheter Placement (Tab 31)</u>
Najeeb Mohideen, MD, Michael Kuettel, MD, MBA, PhD, David Beyer, MD, American Society of Therapeutic Radiation Oncology (ASTRO)

In February 2007 the CPT Editorial Panel created a new CPT code to describe surgical placement of brachytherapy needles or catheters in the pelvis (other than for prostate).
The RUC reviewed the survey results of 57 radiation oncologists considering the physician time, effort, intensity and complexity of the new procedure 55920 *Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application*. The RUC compared the new service to code 52345 *Cystourethroscopy with ureteroscopy;*

with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision) (work RVU = 8.31), and believed that new code 55920 was similar in physician work, time, and intensity. In addition, the RUC believed that the pre-service physician time should be reduced by a total of 25 minutes to reflect the typical patient evaluation and positioning time. The RUC also reviewed a building block methodology using the specialty's reference service 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* (work RVU = 13.31) (090 day global). As an additional approach, the RUC took the reference service code value of 13.31 RVUs and extracted the physician work of code 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23), and its three level 3 evaluation and management office visit (99213) RVUs (2.76 RVUs), resulting in a similar value of 8.32 RVUs. The RUC also determined that for this service the typical patient service would require a pre-service evaluation time of 30 minutes, positioning of 10 minutes, 15 minutes for scrub, dress, and wait, an intra-service time of 90 minutes, and an immediate post service time of 30 minutes, for code 55920. **The RUC recommends a physician work relative value of 8.31 for CPT code 55920.**

Practice Expense
The RUC recommends no direct practice expense inputs in the non-facility setting for this facility only service. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service.

<u>Percutaneous Renal Tumor Cryotherapy (Tab A)</u>
Robert Vogelzang, MD Society for Interventional Radiology (SIR), Sean Tutton, MD, SIR, Geraldine McGinty, MD, American College of Radiology (ACR), Jonathan W. Berlin, MD, ACR, James Giblin, MD, American Urological Association (AUA), William Bruce Shingleton, MD, AUA

In November 2006, the CPT Editorial Panel converted category III code 0135T *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* to a category I code as it determined the service was now performed across the country in multiple locations and the device had FDA approval.

The RUC reviewed two services that were similar in physician time and intensity across specialties to arrive at value for new code 50593. The RUC reviewed code 50592 *Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency* (work RVU = 6.77, 010 day global) and believed 50593 required more physician time due to the complexity of the procedure, but had similar intra-work intensity. The RUC and the specialty determined that the survey respondents overestimated the pre-service time and that pre-service positioning and pre-service scrub, dress, and wait time each should be reduced to 10 minutes to be consistent with code 50592. The RUC recommends 45 minutes of pre-

service evaluation time, less than the survey but significantly more than for 50592 due to the complexity of the typical patient for 50593.

Using code 50592 as an anchor for a building block methodology, the Committee developed a work relative value of 9.08 for 50593. The RUC concurred that the intensity of code 50592 was quite similar to this new service, however 50592 requires one probe and new service 50593 requires four 12 gauge cryoablation probes that results in an additional 30 minutes of intra-service physician time. The intensity of 50592 was utilized, as well as the typical patient pre, intra, and post service physician time components were used in the following building block methodology, that results in the RUC's recommended physician work RVU of 9.08.

The RUC also reviewed code 31239 *Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy* (work RVU = 9.23, 010 day global), as a cross specialty comparison and agreed that while its intra-work was less intense, its total work was similar to 50593. **The RUC recommends a relative work value of 9.08 for code 50593.**

New Technology: The RUC recommends code 50593 to be added to the new technology list.

Physician Time Components	**Intensity**	**Time**	**Associated RVUs**
Pre-Service Eval	0.0224	45	1.01
Pre-Service Position	0.0224	10	0.22
Pre-Service Scrub, dress, wait	0.0081	10	0.08
Immediate Post	0.0224	20	0.45
Intra-service IWPUT of code 50592	0.0640	90	5.76
	Post Operative Visit		
	99238	0.5	0.64
	99213	1	0.92
		Work Value	**9.08**

Practice Expense
The RUC reviewed the specialty recommended direct practice expense inputs for the non-facility and facility settings and made minor modifications to the clinical labor time to reflect the typical patient scenario. **The RUC recommends the attached direct practice expense inputs for code 50593.**

Prostate Laser Enucleation (Tab B)
James Giblin, MD, American Urological Association (AUA), James E. Lingeman, MD, AUA

The CPT Editorial Panel created a new CPT code to provide greater specificity to other prostate procedures currently in CPT. Current CPT code 52648 *Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (Work RVU = 12.00) describes the vaporization of prostate tissue with subsequent prostatic fossa cavitation. This is accomplished by contacting a bare tip laser fiber (under high energy) to the prostate surface and painting the tissue. Tissue underneath the fiber immediately vaporizes. This new code describes the use of the laser fiber to undermine and dissect away large pieces of prostate tissue which migrate into the bladder and are subsequently extracted at the end of the procedure.

The RUC reviewed the specialty society's survey results for new code 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* and discussed the typical patient regarding this new service. The survey results were tight from the 33 respondents who had performed the service a median of 20 times. The service is only safely performed in the facility setting, and typically is for patients who have an enlarged prostate that results in obstructive voiding symptoms. In relation to this new code the RUC also reviewed the specialty's key reference service code 55831 *Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal* (Work RVU = 17.06), and agreed the physician work, time, and complexity was similar to the new service. The RUC concurred that the survey results median work relative value of 17.16 was appropriate for this new procedure. **The RUC recommends a relative work value of 17.16 for new code 52649.**

Practice Expense
The RUC recommends no direct practice expense inputs in the non-facility setting for this facility only service. A practice expense spreadsheet is attached with recommendations for clinical labor staff time reflecting the PERC's 090 day global standard direct practice expense inputs.

Laparoscopic Paravaginal Defect Repair (Tab C)
Robert L. Harris, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG), George A. Hill, MD, FACOG, ACOG

The CPT Editorial Panel revised one code and created two new codes to describe the three approaches to a paravaginal defect repair.

57284 and 57285
Code 57284 *Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse if performed); open abdominal approach* had been the code typically used for both the vaginal and abdominal approaches prior to its revision and the creation of new code 57285 *Paravaginal defect repair (including repair of cystocele, if performed), vaginal approach*. The physician work of code 57284 was valued at 13.51 for the 2007 Medicare Physician Payment Schedule. The RUC agreed that the vaginal approach was less work than the abdominal approach, and with the estimated Medicare utilization from the specialty, the recommended work values result in a work neutral recommendation.

The low of the specialty's survey results for code 57284 of 14.25 was compared by the RUC, to its key reference code 57280 *Colpopexy, abdominal approach* (work RVU = 16.62) and was found to be similar in physician intensity, complexity, and physician time. However, the survey respondents indicated that the physician work value for 57284 was clearly lower than 57280 as its median survey value was 15.50. The specialty society recommended, and the RUC agreed, that the low of the survey results reflects the difference in the value from the reference code and accommodates for work neutrality. The RUC also confirmed that revised 57284, is similar in intra-service time and work RVU of CPT code 57260 *Combined anteroposterior colporrhaphy*. 57284 has 100 minutes of intra-service time and a recommended work RVU of 14.25, while 57260 has 90 minutes, and an RVW of 14.36. Code 57260 was revalued during the RUC's Third Five Year Review. **The RUC recommends a physician work relative value of 14.25 for CPT code 57284.**

The low of the specialty's survey results for code 57285 of 11.52 was compared by the RUC, to its key reference code 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele* (work RVU = 11.42), and was found to be physician work based on intensity, complexity, skill, and stress levels between the two services. The specialty's survey median indicated a physician work value of 13.25, however considering the physician time overall was less than the key reference code and work neutrality considerations, the RUC and the specialty concurred that the low of the specialty survey results reflects the physician work value for CPT code 57285 of 11.52. **The RUC recommends physician work relative value of 11.52 for CPT code 57285.**

57423
The RUC reviewed the specialty society's survey results for this new technology laparoscopic approach to paravaginal defect repair, CPT code 57423 *Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach* (previously reported with an unlisted code) and agreed the survey results from the 35 obstetrics and gynecology physicians represented the appropriate physician work involved in this new service and showed a strong argument for accepting the survey median of 16.00 work RVUs for the service. The survey results were well distributed with the median and the physician time, complexity, and intensity measures indicated this new service was similar to its key reference service code 58543 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; (work RVU = 16.74). **The RUC recommends a specialty society's median survey physician work relative value of 16.00 for new code 57423.**

The specialty also standardized the physician time components from its survey results similar to other Obstetrics and Gynecological surgical procedures. The specialty standardized the pre-service time for evaluation to be 45 minutes, positioning to be 10 minutes, and pre-service scrub dress and wait to be 5 minutes. In addition, the procedures each were standardized to have one level three (99213) and one level two (99212) post operative evaluation and management office visits. The RUC agreed with these reductions in physician time from the survey results.

Practice Expense
The RUC recommends no direct practice expense inputs in the non-facility setting for these facility only services. A practice expense spreadsheet is attached with recommendations for clinical labor staff time reflecting the PERC's 090 day global standard direct practice expense inputs.

The RUC recommends code 57423 be placed on the new technology list.

<u>Laparoscopic Total Hysterectomy (Tab D)</u>
Christopher Sobolewski, MD, FACOG, American College of Obstetricians and Gynecologists (ACOG), George A. Hill, MD, FACOG, ACOG

The CPT Editorial Panel created four new procedure codes to accurately reflect a total hysterectomy in which both the uterine cervix and body are completely detached from their surrounding support structures via a laparoscopic approach, and in which the vaginal cuff is sutured via a laparoscopic approach. Thus, with the exception of simply retrieving the specimen through the vagina, the entire procedure is performed laparoscopically.

Current codes reflect a procedure in which the attachments of the uterine body are secured laparoscopically and then the cervical attachments are secured via a vaginal route; both a laparoscopic and vaginal surgical approach are required for these procedures. The proposed codes describe accomplishing the complete detachment

of the entire uterus and cervix via a laparoscopic approach. A vaginal approach is used only to retrieve the specimen. The vagina is closed via laparoscopic suturing techniques.

In February 2007, the RUC's Research Subcommittee had agreed that the two proposed base codes, 58570 *Laparoscopy, surgical, with total hysterectomy for uterus 250 grams or less* and 58572 *Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 grams* be surveyed utilizing a standard RUC survey instrument and an incremental add-on approach be used to develop RVU recommendations for the subsequent two codes in the family which both include the removal of tube(s) and/or ovary(s). These two subsequent codes are: 58571 *Laparoscopy, surgical, with total hysterectomy for uterus 250 grams or less; with removal of tubes and/or ovary(s),* 58573 *Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 grams; with removal of tubes and/or ovary(s)*

58570 and 58572
The RUC reviewed the specialty society's survey results and key reference codes in order to provide proper rank order among the hysterectomy procedures. The RUC believed the survey results for new codes 58570 and 58572, of over 60 obstetrics and gynecologic physicians, represented the typical physician work involved with these new procedures. The RUC reviewed the specialty's key reference codes; 58550 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;* (work RVU = 14.97)
58552 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)* (work RVU = 16.78), and concurred that the specialty survey results provided the proper relative physician work value for codes 58570 and 58572. The agreed that the incremental difference between a vaginal approach and a total hysterectomy for a large uterus was less apparent than that with a smaller uterus. The RUC considered the vaginal approach for a smaller uterus less overall work than the abdominal laproscopic approach.. The survey results in the intra-service period supported this relationship, where code 58570 has 20 additional minutes of intra-service time than 58550 and code 58571 has 15 more minutes of intra-service time than 58552. **The RUC recommends a relative physician work value of 15.75 for 58570 and 17.56 for 58572.**

58571 and 58573
Based on the agreed RUC Research Subcommittee methodology, the RUC added the incremental difference between 58550 and 58552 of 1.81 to arrive at a recommendation of (14.97 +1.81) 17.56 for 58571. In addition, the RUC added the incremental difference between codes; 58553 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;* (work RVU = 19.96)
58554 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)* (work RVU = 22.98) of 3.02 to 58572 (19.96 + 3.02) to arrive at 22.98 work RVUs for code 58573. The RUC and specialty concurred on that the physician work for codes 58571 and 58573 was

identical codes 58553 and 58554 respectively. **The RUC recommends a physician work relative value for CPT code 58571 of 19.96 and 22.98 for 58573.**

Physician Time Components
Physician time components for codes 58571 and 58572 where derived by maintaining the same pre and post service work throughout the new family of codes and by adding an additional 15 minutes of intra-service work time for codes 58571 and 58573 above the surveyed time of 58570 and 58572 respectively.

CPT Code	Pre-Eval	Pre Position	Pre-Scrub, Dress, wait	Intra-Service	Immediate Post Time	99232	99231	99238	99212	99213	Total Time
58570	45	10	5	120	30	1	1	38	1	2	370
58571	45	10	5	135	30	1	1	38	1	2	385
58572	45	10	5	150	30	1	1	38	1	2	400
58573	45	10	5	165	30	1	1	38	1	2	415

The specialty also standardized the physician time components from its survey results similar to other Obstetrics and Gynecological surgical procedures. The specialty standardized the pre-service time for evaluation to be 45 minutes, positioning 10 minutes, and scrub dress and wait 5 minutes. In addition, the procedures each were standardized to have two level three and one level two post operative office visits. The RUC agreed with these reductions in physician time from the survey results. **The RUC recommends the following physician time components for 58570-58573.**

New Technology: The RUC recommends this family of codes to be added to the new technology list. (Codes 58570, 58571, 58572, 58573)

Practice Expense
The RUC recommends no direct practice expense inputs in the non-facility setting for these facility only services. A practice expense spreadsheet is attached with recommendations for clinical labor staff time associated with typical facility service based on the 90 day global RUC standards.

<u>Nasolacrimal Duct Balloon Catheter Dilation (Tab E)</u>
Stephen Kamenetzky, MD, American Academy of Ophthalmology (AAO), Neal Freeman, MD, American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS)

The CPT Editorial Panel created one new code to describe the distinct procedure of probing the nasolacrimal duct with transluminal balloon catheter dilation when other probing methods have failed.

The RUC reviewed the survey data for code 68816 *Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation* compared to

the key reference code 68811 *Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia* (Work RVU=2.39). The specialty society indicated and the RUC agreed that the survey 25th percentile work RVU of 3.00 was appropriate in comparison to the reference service and this family of codes. The surveyed code, 68816, intra-service time of 25 minutes was comparable to that of the key reference service with 23 minutes physician intra-service time. The RUC reviewed the surveyed pre-service and immediate post-service times and determined that 30 minutes pre-service and 15 minutes immediate post-service times are similar to the reference code 68811 (30 minutes pre-service and 20 minutes post-service) and are appropriate. The specialty society indicated that CPT code 68816 is more difficult technically than 68811 due to the need to position, identify and follow the inflation-deflation balloon protocol, but is not as technically difficult as probing followed by stent placement, code 68815 *Probing of nasolacrimal duct, with or without irrigation*; *with insertion of tube or stent* (Work RVU=3.24, and 40 minutes intra-service time). Additionally, the mental effort and judgment, technical skill, physical effort and stress associated to perform 68816 were all higher than the key reference service 68811, supporting a slightly higher work RVU. The RUC recommends two level 99212 post-operative visits and a half-day discharge day are required, which is consistent with other codes in this family.

The RUC recommends the survey 25th percentile work RVU of 3.00 for code 68816.

Practice Expense
The RUC reviewed the accepted the direct practice expense inputs for 68816 with the 100 percent assist physician time as indicated.

New Technology
The RUC recommends that CPT code 68816 be placed on the new technology list.

Cardiac MRI (Tab F)
Edward T. Martin, MD, American College of Cardiology (ACC), Geraldine McGinty, MD, American College of Radiology (ACR), Jonathan Berlin, MD, ACR

Improvement in spatial and temporal resolution has expanded the applications of cardiac MRI from predominantly an anatomic test to one that performs accurate physiologic evaluations. Because of this improvement, cardiac MRI is unlike traditional MRI which relies solely on static images to obtain clinical diagnoses. This expansion in technology has led to a test that is now technically more complex to perform and includes more physician work to adjust imaging planes, decide on sequences, evaluate the images, and assimilate the data into an effective treatment plan. Because of the clinical expansion and additional work, new CPT codes and

descriptors were needed to more accurately reflect current cardiac MRI practice. To describe the various combinations and permutations of imaging protocols with sufficient granularity for cardiac MRI of the heart, eight new codes were developed by the CPT Editorial Panel in November 2006. Four of the codes involve contrast and four without contrast. These non-contrast and with contrast, morphology and function, with flow/velocity (for physiologic assessment of values, intra cardiac shunts, etc.) and with pharmacologic stress codes will now accurately depict procedural differences in technique and physician work.

The RUC reviewed the specialty society's survey results for the entire set of codes and heard from the specialty on how the technology had changed, whereas increases in the capabilities of the computers used for MR imaging have allowed the development of software for pulse sequences and post-processing algorithms that were not available at the time when the prior codes (CPT codes 75552-75556) were developed. Current techniques use myocardial enhancement for characterizing myocardial disease, details which were unknown when these codes were originally valued. Furthermore, contrast studies in the past were done largely to look for cardiac tumors, but now require analysis of each of 17 segments of the heart, adding a whole new level of complexity to the present-day studies. The RUC agreed that the new technology had increased the physician work since the typical patient is now also more complex. The RUC agreed that because of the nature of this new technology, the specialty had met the compelling evidence criteria and physician work neutrality should not apply.

75557

The RUC compared the specialty's survey results for new CPT code 75557 to its key reference service 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.26, total physician time = 50). The RUC agreed that the physician time and work RVU of 74183 supported the specialty's median survey RVU of 2.35 (60 minutes of total median survey physician time) for code 75557. The RUC also compared code 75557 to other MRI codes (71550 *Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)* (work RVU = 1.46, physician time = 30) and 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46, physician time = 30) with similar ratios of work RVU/time and concurred that the survey median RVU was appropriate for this new code. **The RUC recommends a physician work relative value of 2.35 for code 75557.**

75558

The RUC reviewed the specialty's survey results for new CPT code 75558 in relation to its key reference service 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU =

1.48, total physician time = 40). The RUC agreed that the work value to physician time ratio of 93350 supported the specialty's median survey RVU of 2.60 (65 minutes of total median survey physician time) for code 75558. In addition, the incremental work similar to that between the base code 75557 and 75558 includes flow/velocity analyses. This is analogous to the work of code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38). Adding the work values of 75557 and 93320 yields 2.73 RVUs and supports the more conservative survey median of 2.60 RVUs for code 75558. **The RUC recommends a physician work relative value of 2.60 for code 75558.**

75559

The RUC reviewed the specialty's survey results for new CPT code 75559 in relation to its key reference service 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU = 1.48, total physician time = 40). The RUC agreed that the value and physician time of 75559 supported the specialty's median survey RVU of 2.95 (75 minutes of total median survey physician time) as its recommended value. In addition, the incremental work of interpreting images at rest versus at rest and with exercise has been previously assessed by the RUC. Specifically, code 78478 *Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)* (work RVU = 0.50) is a nuclear cardiology imaging add-on code used when stress imaging is added to rest imaging. Also, stress echo code 93350 (work RVU = 1.48) is 0.56 RVUs higher than rest echo code 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete* (work RVU = 0.92). These values support the survey median for 75559 of 2.95, which is 0.60 higher than the base code 75557 (recommended work RVU = 2.35). **The RUC recommends a physician work relative value of 2.95 for code 75559.**

75560

The RUC reviewed the specialty's survey results for new CPT code 75560 in relation to its key reference service 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU = 1.48, total physician time = 40). The RUC agreed that the value and physician time of 75560 supported the specialty's median survey RVU of 3.00 (80 minutes of total median survey physician time) as its recommended value. In addition, the incremental work of velocity/flow analysis, code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38), and the incremental value of imaging at stress for echo or nuclear images is 0.5 - 0.56, as discussed in the above for 75559. Adding these to the

survey median RVU for the base code 75557 would yield 2.35 + 0.38 + 0.5 = 3.23. By this analysis, the survey median for 75560 of 3.00 was conservative to the RUC. Similarly, adding the increments between 75557 and 75558 (2.60 – 2.35 =0.25) and between 75557 and 75559 (2.95 – 2.35 = 0 .60) yields 2.35 +0 .25 + 0.60 = 3.20. The RUC determined that this building block approach also suggests the survey median for 75560 of 3.00 is appropriate. Lastly, the RUC also agreed that evaluation and management code 99205 *Office or other outpatient visit for the evaluation and management of a new patient...* (work RVU = 3.00), as having similar overall physician work. **The RUC recommends a physician work relative value of 3.00 for code 75560.**

75561
The RUC reviewed the specialty's survey results for new CPT code 75561 in relation to its key reference service 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.26) and 50 minutes. The RUC agreed that the ratio of RVU/time ratio (work RVU = 2.26, physician time = 50 minutes) for 74183 is similar to the ratio of survey medians for 75561 (work RVU = 2.75, physician time = 65 minutes). The RUC agreed that code 75561 was appropriately rank ordered within its family with a physician work relative value of 2.60. **The RUC recommends a physician work relative value of 2.60 for code 75561.**

75562
The RUC reviewed the specialty's survey results for new CPT code 75562 in relation to its key reference service 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.26) and 50 minutes. The RUC agreed that the ratio of RVU/time ratio (work RVU = 2.26, physician time = 50 minutes) for 74183 is similar to the ratio of survey medians for 75561 (work RVU = 2.86, physician time = 75 minutes). The RUC agreed that code 75562 was appropriately rank ordered within its family with a physician work relative value of 2.86. **The RUC recommends a physician work relative value of 2.86 for code 75562.**

75563
The RUC compared the specialty's survey results for new CPT code 75563 to its key reference service 78492 *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress* (work RVU = 1.87, total physician time = 55). The RUC agreed that the recommended value and physician time of 75563 supported the specialty's median survey RVU of 3.00 (82.50 minutes of total median survey physician time) as its recommended value. The RUC agreed that the ratio of work RVUs to time between the key reference service and code 75563 supports the median survey work RVU of 3.00 and maintains proper rank order within the family of codes. Lastly, the RUC also agreed that evaluation and management code 99205 *Office or other outpatient visit for the evaluation and*

management of a new patient... (work RVU = 3.00), as having similar overall physician work. **The RUC recommends a physician work relative value of 3.00 for code 75563.**

75564
The RUC reviewed the specialty's survey results for new CPT code 75564 in relation to its key reference service 78492 *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress* (work RVU = 1.87, total physician time = 55). The RUC agreed that the value and physician time of 75564 supported the specialty's median survey RVU of 3.35 (85 minutes of total median survey physician time) as its recommended value. In addition, if 75560 is used as a base code (recommended work RVU = 3.00) and the increment between 75557 and 75561 is added (0.40 RVUs), the sum is 3.40, which is similar to the survey median for 875564 of 3.35. **The RUC recommends a physician work relative value of 3.35 for code 75564.**

The RUC agreed that the median survey results were appropriate for the entire family of codes, however, the immediate post service time for each code seemed excessive at 15 minutes. The specialty society explained that there is significant time spent in discussion with the referring physician and the patient in the post service period, however it was agreed that a 5 minute reduction in the immediate post service time was warranted to reflect the time of similar procedures. The RUC recommends an immediate post-service time reduction of 5 minutes from the specialty survey results, so that there is a total of 10 minutes immediate post-service time for each service in the family.

The RUC compared the physician work required to perform the services to all the key reference codes and to the comprehensive new patient evaluation and management code 99205 (work RVU = 3.00). The RUC also reviewed existing codes with imaging contrast and without imaging contrast and agreed that the work RVU interval was similar or below others and therefore seemed appropriate for these new procedures.

New Technology: The RUC recommends this family of codes to be added to the new technology list.

Practice Expense:
The RUC reviewed the practice expense recommendations for this new set of Cardiac MRI procedures and made minor adjustments to the clinical labor recommendations from the specialty society to reflect a more typical patient scenario. The RUC understood that these procedures would typically be performed only in the non-facility setting. The RUC recommends the attached practice expense direct inputs.

PET Imaging (Tab G)
Gary L. Dillehay, MD, Society of Nuclear Medicine (SNM), Kenneth McKusick, MD, SNM, Geraldine McGinty, MD, American College of Radiology (ACR)

At its February 2007 meeting, the CPT Editorial Panel revised a family of position emission tomography services, 78811-78816, by removing the words "tumor imaging" from the current descriptors. With this change, these services may be reported for other indications, such as for infection. The specialty society purported that the coding change (removing the indication for the procedure) was editorial in nature, consistent with CPT policy, and is in concert with most other codes in the 70000 series. The Panel referred the determination of potential changes to physician work as a result of the descriptor change to the RUC for consideration At the April 2007 RUC meeting, the RUC concluded, based on a review of the coding proposal and the specialty society presentation, that the removal of "tumor imaging" from CPT codes 78811-78816 is editorial in nature and does not require any review of the physician work involved in the service. **The RUC recommends that the current work RVUs be maintained for CPT codes 78811-78816.**

New Technology
The services described in CPT codes 78811-78816 do not involve new technology, however, the services do meet the criteria for inclusion on the new technology list because they include established technology used in a new way. **The RUC recommends that codes 78811-78816 be added to the new technology list to review potential changes in valuation after experience in reporting of these services has occurred**.

Immune Globulin Subcutaneous Infusion (Tab H)
Donald Aaronson, MD, JD, MPH, Joint Council of Allergy, Asthma, and Immunology (JCAAI), Charles H. Kirkpatrick, MD, American Academy of Allergy, Asthma, and Immunology (AAAAI)

In November 2006, the CPT Editorial Panel created three new codes to provide more specificity to current infusion codes. Current infusion codes describe intravenous routes only. Adding "subcutaneous" as a route of infusion allows for more appropriate coding in the clinical setting. Where patients must be monitored for reaction to the immune globulin when it is first introduced.

90769
The RUC reviewed the specialty society's survey results and recommendations for new CPT code 90769, *Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour including pumping set up and establishment of subcutaneous infusion site(s)*. The specialty society's key reference code 96413 *Chemotherapy administration, intravenous infusion*

technique; up to 1 hour, single or initial substance/drug (work RVU = 0.28) was believed to involve more stress, mental effort, and physician judgment than the surveyed code. The specialty's other reference code, 90765, *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21), was deemed more appropriate. The RUC agreed that the work inherent in new code 90769, is primarily supervisory and identical to the work involved in 90765. **The RUC recommends a physician work RVU of 0.21 for code 90769.** (with pre-service time of 5 minutes, intra-service time of 10 minutes, and post-service time of 2 minutes for CPT)

90770

The RUC reviewed the specialty society's survey results and recommendations for new CPT code 90770, *Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional (list separately in addition to code for primary procedure) (Report 90770 with 90769) (Report 90770 for infusion intervals of greater than 30 minutes beyond one hour increments.* The RUC agreed that the work inherent in the service is primarily supervisory and identical to the work involved in its key reference service 90766, *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)* (work RVU = 0.18). The RUC agreed that code 90770 required an additional two minutes of physician time, but was less intense than 90766. **The RUC recommends a work RVU of 0.18 for code 90770.** (with pre-service time of 0 minutes, intra-service time of 5 minutes, and post-service time of 0 minutes for 90770)

90771

The specialty society clarified the process of performing CPT 90771, *Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set up with establishment of new subcutaneous infusion site(s) (list separately in addition to 90769) (Report 90771 with 90769) (Report 90769 and 90771 only once per encounter).* After considering the specialty society presentation, the RUC determined that there was no physician work involved in performing the service and should be considered practice expense only. **The RUC recommends that 90771 be valued as practice expense only (work RVU = 0.00).**

New Technology: The RUC recommends this family of codes to be added to the new technology list.

Practice Expense

The RUC reviewed the specialty society's practice expense inputs for this new family of CPT codes. The RUC and the specialty agreed that the codes would typically not be billed with an evaluation and management code and therefore required additional clinical labor time for meeting and greeting the patient and for completing post service medical record documentation. In addition, the RUC

agreed that there would be no vital signs taken, and no clinical monitoring for the addition of an infusion pump in code 90771, and the mixture of additional drugs would not require as much time as the first batch and reduced the clinical labor time from 7 minutes to 3. The RUC recommends no practice expense inputs for the facility setting and the following attached direct inputs for the non-facility setting.

Electronic Analysis of Implanted Neurostimulator Pulse Generator System (Tab I)

Joel V. Brill, MD, American Gastroenterological Association (AGA), Maurits Wiersema, MD, AGA, John I. Allen, MD, MBA, AGA, Klaus Mergener, MD, PhD, American Gastointestinal Endoscopy Association (ASGE)

The CPT Editorial Panel replaced Category III codes with three new codes to report the electronic analysis of an implanted neurostimulator pulse generator system. Electrical stimulation of the stomach is a treatment for patients with end-stage gastroparesis who are diabetic and/or post-surgical gastroparesis with drug refractory nausea and vomiting. These codes were originally presented at the February 2007 RUC meeting, however, the specialty society requested that this issue be referred to the April 2007 RUC meeting as they believed that their survey data was flawed and wished to conduct a new survey to evaluate these procedures.

95980

The RUC reviewed the specialty society's survey results for CPT code 95980 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming* and thoroughly discussed the physician time and work involved with this service. The RUC agreed with the specialty society that the surveyed physician time for this service does not accurately reflect the service and reduced the surveyed pre-, intra- and post service times dramatically. The specialty society and RUC recommended physician for this procedure are pre-service: 3 minutes, intra-service: 24 minutes, and post-service: 5 minutes. This is an overall reduction of 38 minutes from the surveyed data. The RUC reviewed the specialty society recommended reference service, 93742 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber or wearable cardioverter-defibrillator system, with reprogramming* (Work RVU=0.91). The RUC noted that the intra-service time of the surveyed code was lower than the reference code, 24 minutes and 30 minutes respectively. Additionally, the RUC noted that both codes had similar complexity. Therefore, the RUC agrees with the specialty society recommended value of 0.80 RVUs as this

value appropriately places this service in comparison to the reference code, 93742. **The RUC recommends 0.80 work RVUs for 95980.**

95981

The RUC reviewed the specialty society's survey results for CPT code 95981 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming* and thoroughly discussed the physician time and work involved with this service. The RUC agreed with the specialty that the surveyed time for this service does not accurately reflect the service and reduced the surveyed pre-, intra- and post service times dramatically. For this procedure, the physician times that are recommended by the specialty society and the RUC are pre-service: 2 minutes, intra-service: 10 minutes, and post-service: 5 minutes. This is an overall reduction of 13 minutes from the surveyed data. The RUC reviewed the specialty society recommended reference service, 92020 *Gonioscopy (separate procedure)* (Work RVU=0.37). The RUC noted that the total-service time of the surveyed code was lower than the reference code, 17 minutes and 20 minutes respectively. Additionally, the RUC noted that both codes had similar complexity. Therefore, the RUC agrees with the specialty society recommended value of 0.30 RVUs as this value appropriately places this service in comparison to the reference code, 92020. **The RUC recommends 0.30 work RVUs for 95981.**

95982

The RUC reviewed the specialty society's survey results for CPT code 95982 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming* and thoroughly discussed the physician time and work involved with this service. The RUC agreed with the specialty that the surveyed time for this service does not accurately reflect the time required to perform the service and reduced the surveyed pre-, intra- and post service times dramatically. For this procedure, the specilaty society and RUC recommended physician times are pre-service: 2 minutes, intra-service: 17 minutes, and post-service: 5 minutes. This is an overall reduction of 13 minutes from the surveyed data. The RUC reviewed the reference service, 99307 *Subsequent nursing facility care,* (Work RVU=0.60). The RUC noted that the total-service time of the surveyed code was higher than the reference code, 24 minutes and 20 minutes respectively. Additionally, the RUC noted that both codes had similar complexity. Therefore, the RUC agrees with the specialty society recommended value of 0.65 RVUs as this value appropriately places this service in comparison to the reference code. **The RUC recommends 0.65 RVUs for 95982.**

Practice Expense:
The RUC made slight modifications were made to the clinical labor time recommended by the specialty society to more accurately reflect the work of the clinical labor performing these procedures. These modifications included the removal of a follow-up phone call in the facility setting, and time reductions in reviewing the patient's chart and preparing the room. All other practice expense recommendations were accepted.

New Technology List:
As these codes were previously reported using the Category III codes, the RUC recommends that these services be added to the New Technology List.

Ocular Photoscreening (Tab J)

At the February 2007 CPT Editorial Panel meeting, a pediatric physician provided evidence indicating that since 2003, ocular photoscreening utilization has increased with over 5,000 photoscreening units currently in circulation. The CPT Editorial Panel recognized widespread use of the ocular photo screening Category III code and approved that this code be moved to Category I status.

The RUC initiated the standard Level of Interest process in which specialty societies may survey physicians performing this procedure and present work relative value recommendations to the RUC. No specialty societies indicated an interest in providing a work relative value recommendation.

Ophthalmology and pediatrics both indicated no interest in developing a recommendation for this code. **Therefore, the RUC has no recommendation for physician work or practice expense for code 99174 *Ocular photoscreening with interpretation and report, bilateral.***

Team Conferences (Tab K)
Alan Lazaroff, MD, American Geriatrics Society (AGS)

In November 2006, the CPT Editorial Panel created CPT codes 99365 *Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family, 30 minutes or more; participation by physician* and 99367 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician* to differentiate team conferences at which the patient is present and when the patient is not present.

The CPT Editorial Panel also developed new codes corresponding to non-physician services. The RUC reviewed and submitted the following recommendations on the physician (MD/DO) services only. The HCPAC

independently reviewed and submitted separate recommendations on the non-physicians services.

The CPT Executive Committee subsequently reconsidered CPT code 99365. Discussions initiated by the RUC process indicated that team conference services by the physician with the patient and/or family present may be reported using appropriate E/M codes. A research of materials from the creation of the E/M codes indicates that the language concerning face-to-face time and counseling and coordination of care appears to have been included so as to address meetings conducted for the purpose of coordinating care. The Executive Committee confirmed that the E/M codes would be appropriate when counseling and coordination of care dominate the service and the patient and/or family is present. It is unlikely any significant number of team conferences would not be for the purpose of counseling and/or coordination of care. The E/M codes have greater flexibility than a single code for a team conference by a physician, patient and/or family present. Therefore, the RUC proposed the CPT code 99365 be rescinded. The introductory text from the team conference section is revised to account for this interpretation by removing other restrictions and referencing E/M. The requirement for direct participation in the care of the patient remains in response to concerns that the E/M codes would be improperly reported when the physician role was simply to attend a conference about the patient. **The CPT Executive Committee recommends that CPT code 99365 be rescinded.**

The RUC reviewed the survey data for 99367 and compared it to its reference code 99374 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment* (Work RVU=1.10). The RUC agreed that 99374 was a good reference for the surveyed code as both codes are non-face-to-face services. Although, when comparing the two codes, the RUC noted that 99374 was deemed to be a slightly more intense procedure to perform and had slightly more total service time associated with it as compared to the surveyed code (40 minutes and 34 minutes, respectively), the RUC believed these two codes to be equal in overall work. Therefore, the RUC recommends a work RVU of 1.10 RVUs for 99367 which is a value slightly below the 25th percentile of the survey data. **The RUC recommends 1.10 work RVUs for 99367.**

Practice Expense:
The RUC recommends no practice expense inputs for 99367.

Smoking Cessation (Tab L)
Scott Manaker, MD, PhD, American College of Physicians (ACP) American College of Chest Physicians (ACCP), Allan Plummer, MD, American Thoracic Society (ATS)

In response to recent developments in the area of tobacco control, the CPT Editorial Panel created two new codes to report tobacco counseling cessation services. Currently there are existing G-codes to report these services, G0375 *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes* (CMS Assigned Value of 0.24 RVUs) and G0376 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (CMS Assigned Value of 0.48 RVUs).

99406 - *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*

The RUC reviewed the survey results for CPT code 99406 and agreed with the specialty society that the pre-service and post-service physician times as recommended by the survey respondents did not accurately reflect the service. Therefore, the RUC accepted the specialty society recommended modified physician times of no pre-service time and no post-service time as this procedure is typically billed with an evaluation and management service. The RUC determined that the pre-service and post-service time for the smoking cessation counseling would be accounted for in the evaluation and management service. The RUC compared the surveyed code to its reference code 99211 *Office or other outpatient visit for the evaluation and management of an established patient,* (Work RVU=0.17). The RUC noted that the total service times for both codes was the same, 7 minutes. However, the RUC noted that the intensity/complexity measures demonstrated that the surveyed code was a more intense service to provide as compared to the reference code, 99211. Given the same total service time and that the surveyed code has more intensity and complexity associated with it as compared to the reference code, the RUC determined that the current work RVU associated with G0375 would be an appropriate crosswalk for this service, 0.24 RVUs. This proposed value of 0.24 RVUs is slightly higher than the 25th percentile of the survey data. **The RUC recommends 0.24 work RVUs for 99406.**

99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*

The RUC reviewed the survey results for CPT code 99407 and agreed with the specialty society that the pre-service and post-service physician times as recommended by the survey respondents did not accurately reflect the service. Therefore, the RUC accepted the specialty society recommended modified times of no pre-service time and no post-service time as this procedure is typically billed with an evaluation and management service. The RUC determined that the pre-service and post-service time for the smoking cessation counseling would be

accounted for in the evaluation and management service. The RUC compared the surveyed code to its reference code 99401 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes,* (Work RVU=0.48). The RUC noted that the total service times for both codes was the same, 15 minutes. Further, the RUC noted that the intensity/complexity measures demonstrated that the surveyed code was a more intense service to provide as compared to the reference code. Given the same total service time and that the surveyed code has more intensity and complexity associated with it as compared to the reference code, the RUC determined that the median of the survey data of 0.50 RVUs was appropriate. This value is further supported by the current work RVU associated with G0376, 0.48 RVUs. **The RUC recommends 0.50 work RVUs for 99407.**

Practice Expense
The RUC recommends one direct practice expense input associated with both of these procedures, a patient education booklet in the non-facility setting.

Alcohol, Drug Screening and Brief Intervention (Tab M)
Chester Schmidt, MD, American Psychiatric Association (APA), Scott Manaker, MD, PhD, American College of Physicians (ACP), Lee Mills, MD, American Academy of Family Physicians (AAFP)

The CPT Editorial Panel created two new codes to report alcohol, drug screening and brief intervention (SBI). SBI describes a type of physician/patient interaction that requires a significant amount of time and additional skills required by the provider to deliver. SBI techniques are discrete, clearly distinguishable clinical procedures that are effective in identifying and ameliorating an under-treated public health epidemic that affects as many as 20% of adults in the United States.

99408 - *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes*
The RUC reviewed the survey results for CPT code 99408 and agreed with the specialty society that the pre-service and post-service physician time as recommended by the survey respondents did not accurately reflect the service. Therefore, the RUC accepted the specialty society recommended modified times of no pre-service time and no post-service time as this procedure is typically billed with an evaluation and management service. The RUC determined that the pre-service and post-service time for the alcohol, drug screening and brief intervention would be accounted for in the evaluation and management service. The RUC compared the surveyed code to its reference code 99402 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes,* (Work RVU=0.98). The RUC noted that the total service times for the reference code were higher than the surveyed code, 30 minutes and 20 minutes respectively. Further, the RUC noted that the intensity/complexity measure of the intra-service time associated with both

procedures was identical and therefore demonstrate that the surveyed code has a similar intensity to the reference code. Given the same intensity and complexity and that the surveyed code has less total service time as compared to the reference code, the RUC agreed with the specialty society's recommendation of 0.65 RVUs which is two-thirds of the work RVU associated with the reference code, 99402. **The RUC recommends 0.65 work RVUs for 99408.**

99409 - *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; greater than 30 minutes* The RUC reviewed the survey results for CPT code 99409 and agreed with the specialty society that the physician time as recommended by the survey respondents did not accurately reflect the service. Therefore, the RUC accepted the specialty society recommended modified times of no pre-service time and no post-service time as this procedure is typically billed with an evaluation and management service. The RUC determined that the pre-service and post-service time for the alcohol, drug screening and brief intervention would be accounted for in the evaluation and management service. The RUC agreed with the specialty society's recommendation that this service typically requires double the time to perform in comparison to 99408 *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes* (RUC recommended Work RVU=0.65). Therefore, the RUC agreed that the appropriate intra-service time for this procedure was 40 minutes. Further the RUC agreed that performing this service would require twice the amount of physician work as 99408 and therefore recommends that 99409 be valued at 1.30 RVUs. The RUC further supported this work RVU by comparing this procedure to 99403 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes* (Work RVU=1.46). Reference code 99403 has slightly more intra-service time as compared to the surveyed code 45 minutes and 40 minutes, respectively with similar intensity. Therefore given its comparison to 99408 and 99403, the RUC agrees that 1.30 work RVUs is an appropriate value for this procedure. **The RUC recommends 1.30 work RVUs for 99409.**

Practice Expense:
The RUC recommends one practice expense input associated with each of these procedures, a patient education booklet in the non-facility setting.

XI. Relative Value Recommendations for Five-Year Review

Audiology Services (Tab N)
Robert Fifer, PhD, American Speech-Language-Hearing Association (ASHA), Peter Weber, MD, American Association of Otolaryngology-Head and Neck Surgeons (AAO-HNS)

The American Speech-Language-Hearing Association (ASHA) met with CMS on September 8, 2006, and requested that CMS agree to consider establishing physician work relative values for services provided by audiologists. ASHA specifically requested that the professional work effort for audiologists providing these services be reflected in the work relative values rather than in the practice expense relative values. CMS responded to ASHA on November 14, 2006, and indicated that they agree to consider this possibility further. CMS advised the RUC and HCPAC that if the committee recommends the use of work values for the audiology services, CMS will consider their recommendation. CMS also indicated that the practice expense relative values would, of course, need to be adjusted as appropriate to avoid double counting of the audiologists' work effort.

The American Academy of Otolaryngology-Head and Neck Surgeons (AAO-HNS) and ASHA surveyed nine audiology codes. Each society submitted two different survey results and work relative value recommendations. However, at the April 2007 RUC meeting, AAO-HNS and ASHA convened and revised their recommendations and presented one joint recommendation. All the recommendations are based on comparisons to other reference services. The time data results from a blend of the survey data and discussion between the two specialty societies. All E/M should be reported separately. However, the RUC considered:

Codes 92557 and 92567 are reported together 95% of the time in the Medicare population;
Codes 92567 and 92568 are reported together 98% of the time in the Medicare population; and
Codes 92568 and 92569 are reported together 93% of the time in the Medicare population.
Therefore, pre- and post-service work should be at a minimum.

92557 ***Comprehensive audiometry threshold evaluation and speech recognition***
AAO-HNS and ASHA presented a joint recommendation for code 92557 indicating a work RVU of 0.60 and 3 minutes pre-service, 20 minutes intra-service and 5 minutes post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92557 by comparing it to four reference services:

77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction* (Work RVU=0.60, 10 minutes pre-, 20 minutes intra-, and 5 minutes post-service time);
92526 *Treatment of swallowing dysfunction and/or oral function for feeding* (Work RVU=0.55, 10 minutes pre-, 45 minutes intra-, and 15 minutes post-service time);
97605 *Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters* (Work RVU=0.5, 10 minutes pre-, 30 minutes intra-, and 10 minutes post-service time); and
97002 Physical therapy re-evaluation (Work RVU=0.60, 2 minutes pre-, 18 minutes intra-, and 5 minutes post-service time)

The RUC determined that 92557 required similar work and time to perform as the above reference services**.** The RUC agreed that 3 minutes pre-service, 20 minutes intra-service and 5 minutes post-service time was appropriate for code 92557. **The RUC recommends a work RVU of 0.60 for code 92557.**

92567 ***Tympanometry (impedance testing)***
AAO-HNS and ASHA presented a joint recommendation for code 92567 indicating a work RVU of 0.20 and 1 minute pre-service, 4 minutes intra-service and 1 minute post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92567 by comparing it to four reference services:

77080 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)* (Work RVU=0.20, 1 minute pre-, 4 minutes intra-, and 1 minute post-service time);
92260 *Ophthalmodynamometry)* (Work RVU=0.20, 5 minutes pre-, 12 minutes intra-, and 5 minutes post-service time);
97016 *Application of a modality to one or more areas; vasopneumatic devices* (Work RVU=0.18, 2 minutes pre-, 14 minutes intra-, and 2 minutes post-service time); and
99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* (Work RVU=0.17, no pre-, 5 minutes intra-, and 2 minutes post-service time).

The RUC determined that 92567 required similar work and time to perform as the above reference services. The RUC agreed that 1 minute pre-service, 4 minutes intra-service and 1 minute post-service time is appropriate for code 92567. **The RUC recommends a work RVU of 0.20 for code 92567.**

92568 ***Acoustic reflex testing; threshold***
AAO-HNS and ASHA presented a joint recommendation for code 92568 indicating a work RVU of 0.29 and 1 minute pre-service, 8 minutes intra-service and 1 minute post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92568 by comparing it to three reference services:

74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (Work RVU=0.27, 1 minute pre-, 3 minutes intra-, and 1 minute post-service time);
93922 *Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)* (Work RVU=0.25, 7 minutes pre-, 18 minutes intra-, and 7 minutes post-service time); and
94060 *Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration* (Work RVU=0.31, 5 minutes pre-, 10 minutes intra-, and 5 minutes post-service time).

The RUC determined that 92568 required similar work and time to perform as the above reference services. The RUC agreed that 1 minute pre-service, 8 minutes intra-service and 1 minute post-service time was appropriate for code 92568. **The RUC recommends a work RVU of 0.29 for code 92568.**

92569 ***Acoustic reflex testing; decay***
AAO-HNS and ASHA presented a joint recommendation for code 92569 indicating a work RVU of 0.20 and 1 minute pre-service, 4 minutes intra-service and 1 minute post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92569 by comparing it to four reference services:

77080 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)* (Work RVU=0.20, 1 minute pre-, 4 minutes intra-, and 1 minute post-service time);
92260 *Ophthalmodynamometry* (Work RVU=0.20, 5 minutes pre-, 12 minutes intra-, and 5 minutes post-service time);
97016 *Application of a modality to one or more areas; vasopneumatic devices* (Work RVU=0.18, 2 minutes pre-, 14 minutes intra-, and 2 minutes post-service time); and
99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* (Work RVU=0.17, no pre-, 5 minutes intra-, and 2 minutes post-service time).

The RUC determined that 92569 required similar work and time to perform as the above reference services. The RUC agreed that 1 minute pre-service, 4 minutes

intra-service and 1 minute post-service time was appropriate for code 92569. **The RUC recommends a work RVU of 0.20 for code 92569.**

92579 ***Visual reinforcement audiometry (VRA)***
AAO-HNS and ASHA presented a joint recommendation for code 92579 indicating a work RVU of 0.70 and 4 minutes pre-service, 25 minutes intra-service and 5 minutes post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92579 by comparing it to four reference services:

74251 *Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube* (Work RVU=0.69, 2 minutes pre-, 32 minutes intra-, and 4 minutes post-service time);
92060 *Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)* (Work RVU=0.69, 5 minutes pre-, 30 minutes intra-, and 5 minutes post-service time);
97605 *Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters* (Work RVU=0.55, 10 minutes pre-, 30 minutes intra-, and 10 minutes post-service time);
92163
92520 *Laryngeal function studies (ie, aerodynamic testing and acoustic testing)* (Work RVU=0.75, 10 minutes pre-, 11 minutes intra-, and 10 minutes post-service time).

The RUC determined that 92579 required similar work and time to perform as the above reference services. The RUC agreed that 4 minutes pre-service, 25 minutes intra-service and 5 minutes post-service time was appropriate for code 92579. **The RUC recommends a work RVU of 0.70 for code 92579.**

92601 ***Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming***
AAO-HNS and ASHA presented a joint recommendation for code 92601 indicating a work RVU of 2.30 and 15 minutes pre-service, 82 minutes intra-service and 20 minutes post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92601 by comparing it to two reference services:

01968 *Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)* (Work RVU=2.00, 10 minutes pre-, 75 minutes intra-, and 10 minutes post-service time) and

30906 *Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent* (Work RVU=2.45, 30 minutes pre-, 60 minutes intra-, and 40 minutes post-service time).

The RUC determined that 92601 required similar work and time to perform as the above reference services. The RUC agreed that 15 minutes pre-service, 82 minutes intra-service and 20 minutes post-service time was appropriate for code 92601. **The RUC recommends a work RVU of 2.30 for code 92601.**

92602 ***Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming***
AAO-HNS and ASHA presented a joint recommendation for code 92602 indicating a work RVU of 1.30 and 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92602 by comparing it to four reference services:

19100 *Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)* (Work RVU=1.27, 15 minutes pre-, 30 minutes intra-, and 15 minutes post-service time)
96101 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (Work RVU=1.86, 7 minutes pre-, 60 minutes intra-, and 0 minutes post-service time);
92310 *Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia* (Work RVU=1.17, 8 minutes pre-, 25 minutes intra-, and 24 minutes post-service time); and
97003 *Occupational therapy evaluation* (Work RVU=1.20, 7 minute pre-, 45 minutes intra-, and 5 minutes post-service time).

The RUC determined that 92602 required similar work and time to perform as the above reference services. The RUC agreed that 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service time was appropriate for code 92602. **The RUC recommends a work RVU of 1.30 for code 92602.**

92603 ***Diagnostic analysis of cochlear implant, age 7 years or older; with programming***
AAO-HNS and ASHA presented a joint recommendation for code 92603 indicating a work RVU of 2.25 and 20 minutes pre-service, 82 minutes intra-service and 20 minutes post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92603 by comparing it to two reference services:

01968 *Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)* (Work RVU=2.00, 10 minutes pre-, 75 minutes intra-, and 10 minutes post-service time) and
30906 *Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent* (Work RVU=2.45, 30 minutes pre-, 60 minutes intra-, and 40 minutes post-service time).

The RUC determined that 92603 required similar work and time to perform as the above reference services. The RUC agreed that 20 minutes pre-service, 82 minutes intra-service and 20 minutes post-service time was appropriate for code 92603. **The RUC recommends a work RVU of 2.25 for code 92603.**

92604 *Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming*
AAO-HNS and ASHA presented a joint recommendation for code 92604 indicating a work RVU of 1.25 and 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service time. The RUC reviewed similar services performed by physicians and non-physicians to appropriately value this service. The specialty societies supported the recommended value for 92604 by comparing it to four reference services:

19100 *Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)* (Work RVU=1.27, 15 minutes pre-, 30 minutes intra-, and 15 minutes post-service time)
96101 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (Work RVU=1.86, 7 minutes pre-, 60 minutes intra-, and 0minutes post-service time);
92310 *Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia* (Work RVU=1.17, 8 minutes pre-, 25 minutes intra-, and 24 minutes post-service time); and
97003 *Occupational therapy evaluation* (Work RVU=1.20, 7 minute pre-, 45 minutes intra-, and 5 minutes post-service time).

The RUC determined that 92604 required similar work and time to perform as the above reference services. The RUC agreed that 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service time was appropriate for code 92604. **The RUC recommends a work RVU of 1.25 for code 92604.**

Practice Expense
The RUC recommends removing the associated audiologists' time from the direct practice expense inputs, as all physician and audiologist work is captured in the work RVU.

Anesthesia Services (Tab O)

The RUC convened a workgroup to consider the request from CMS to assign Post-Induction Period Procedure Anesthesia (PIPPA) intensity. In addition, CMS referred to the RUC the question of how and whether to apply the E/M update to anesthesia procedures. *See Federal Register/Vol. 71, No. 231/December 1, 2006 page 69733.*

Conference Call, March 1, 2007
The Anesthesia Workgroup convened two conference calls, March 1 and April 19, 2007. On the first call, the American Society of Anesthesiologists (ASA), explained the CMS correspondence to date and the undervaluation of anesthesia services. ASA presented a linear regression model to expand upon the work performed in the second Five-Year Review. The ASA analysis was referenced in the CMS request in the summer of 2006.

ASA maintained the following:

1. The previous workgroup had established fair and reasonable inputs for most elements of the building block presented in the second Five-Year Review.
2. ASA contended that the aggregate intensities in the post-induction period from the previous analysis were flawed.
3. RUC actions between the second and third Five-Year Review established relevant benchmarks for considering anesthesia work.

On this call, ASA presented the regression model and entertained questions from the Workgroup. Additionally, ASA engaged an independent economist to review their model for statistical validity. Michael O'Grady, PhD, was present on the first call and answered questions by the Workgroup. After discussion, the Workgroup suggested that:

1. ASA consider methods to demonstrate the validity that all elements of Anesthesia work increases in anesthesia base units.
2. Medicare frequency and charge information be used to extend the number of services considered in their review.
3. AMA obtain a second review of the methodology by an AMA staff economist.

Second Conference Call, April 19, 2007

- ASA presented data obtained between the first two calls to provide additional evidence to support the relationship between base units and anesthesia work.
- ASA surveyed an expert panel to determine the elements of work present in the post-induction period for the 19 originally studied codes and several additional codes as well. The results of this survey demonstrated a fairly linear relationship between the number of elements and the base unit values assigned to those services.
- ASA summarized their points of agreement and disagreement with the previous analysis. ASA agreed with all of the previous allocations except the post-induction period aggregate intensities.
- The workgroup briefly discussed the analysis prepared by AMA economist, Kurt Gillis, PhD. Dr. Gillis suggested that a review of additional services may improve the predictive power of the model. Dr. Gillis also discussed the importance of assigning correct intensities for the floor and ceiling of the regression model as these have significant impact of the results of the model.
- The specific charge from CMS to the RUC was to review the range of intensities in the PIPPA period.

The Workgroup requested that ASA perform the following tasks for presentation at the Anesthesia Workgroup April 2007 RUC meeting:

1. Expand the list of codes being reviewed to encompass at least 70% of all allowed Medicare charges for anesthesia services.
2. Compare the PIPPA intensity regression to a retrofitted result from the quintile time allocations developed in the second Five-Year Review using the new proposed intensities.
3. Workgroup requested that the economists be available at the Workgroup session to answer any questions on the regression analysis.

April 26, 2007 RUC Meeting

ASA provided all the building block elements for the additional codes requested using regression to predict pre-, post-, prep, induction period procedure work and the PIPPA work. These codes along with the original 19 codes, account for 81% of all Medicare allowed charges for the anesthesia code set.

The ASA presented the retrofitted data, which demonstrated a 0.7% difference between the regression model of PIPPA work and the quintile model of work.

The RUC reviewed the additional codes and determined that rather than using regression for the non-PIPPA work elements, a bottom-up building block approach be used to determine values for the non-PIPPA work independent of the regression model. E/M proxies for the pre and post work would be appropriate values for the pre- and post-work. The RUC selected E/M levels of service consistent with the assignments made during the second Five-Year Review. The

levels of E/M services increased in base unit ranges. The RUC assigned work values for the prep work and induction period procedure work consistent with the work values used in the second Five-Year Review. Like the E/M equivalents, these values did increase with higher base units. Additionally, the RUC considered the special circumstance of one-lung ventilation in several of the anesthesia codes and recommend an increased value for those services. The RUC recommends that where the building block values differed from the original 19 codes, the original values be used.

Pre-Anesthesia Time
The base units were referenced to the same E/M services by base unit range, as was previously performed in the second Five-Year Review building block.

- Codes with a base unit of 3 are referenced to 99201 (work RVU=0.45);
- Codes with a base unit of 4 are referenced to blend of 99201/99202 (work RVU=0.67);
- Codes with a base unit of 5-15 are referenced to 99202 (work RVU=0.88); and
- Codes with a base unit of 16-30 are referenced to code 99252 (work RVU=1.50).

Preparation Time
The equipment and supply preparation time was linked to the original 19 codes reviewed in the 2nd Five Year Review and carried throughout each of the additional codes per base unit.

- Codes with a base unit of 3 are assigned an RVU of 0.14
- Codes with base units 4-14 are assigned 0.21
- Codes with base units 15-30 are assigned 0.28

Induction Period
The induction period is calculated based on the survey data of the original 19 codes. The RVU component per base unit varied based on survey data, therefore the Workgroup took the average RVUs of each base unit segment of the previous 19 codes.

- Codes with a base unit of 3 = 0.67
- Codes with base unit of 4 = 0.80
- Codes with base unit of 5 = 0.84
- Codes with base unit of base unit 6-12 = 1.12
- Codes with base units of 13-19 = 1.34
- Codes with base units of base unit 20-30 = 2.01 (two-lung vent cases are at 1.34) In the special circumstance of one-lung ventilation due to the increased work involved in this situation, these codes were assigned an IPP work value of 2.01. A total of 6 codes out of more than 270 anesthesia

codes involve one lung ventilation typically, representing 0.37% of Medicare allowed charges.

Post-Induction Period Procedure Anesthesia (PIPPA)
The RUC recognized that regression was a necessary element for calculating PIPPA work for codes other than the original 19 which used a quintile intensity model to determine work, which was reviewed and validated extensively by the second Five-Year Review Workgroup. The RUC was satisfied that the retrofitted quintile data proved that regression accurately predicts PIPPA work. The RUC discussed the floor and ceiling proposed by ASA for the regression, and agreed that the floor could be no less than 0.031 and a ceiling of 0.090 was reasonable. The rationale supporting the range includes:

1. The RUC has previously approved and reaffirmed that moderate sedation maintenance performed by a second provider, CPT code 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,* has an intensity of 0.031. The Workgroup determined that this was a reasonable floor for anesthesia PIPPA. Additional codes supporting this rationale includes: 50391 *Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)* intensity 0.043 and code 90760 *Intravenous infusion, hydration; initial, up to 1 hour,* intensity 0.031.
2. For the ceiling, the workgroup agreed that for the most highly valued service, code 00796 *Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)*, the PIPPA work intensity was equal to critical care intensity of 0.090.

Post-Anesthesia Time
The post-anesthesia time is referenced to codes the E/M service levels assigned to the original 19 codes.

- Codes with a base unit of 3 are referenced to code 99211 (work RVU=0.17),
- Codes with base units 4-16 are referenced to 99231 (work RVU=0.76) and
- Codes with base units 17-30 are referenced to a blend of 99232/99231 (work RVU=1.08).

The ASA raised concern with the assignment of code 99211 to codes assigned a base unit of 3. The ASA contends that the work in the post anesthesia time is more than that of 99211, which does not require the presence of a physician. While the RUC agreed that the work performed by the anesthesiologist is at a higher level than that of 99211, to be consistent with the original work of the

second Five-Year Review Workgroup, they chose to keep the level assigned to 3 base unit codes at 99211. The RUC advised the ASA could request the issue be re-evaluated at a later date. The ASA did agree with the overall assignment of values of Post-Anesthesia Time.

Lastly, ASA revised the model to incorporate the building block changes, which the workgroup reviewed and approved. The net undervaluation of anesthesia work was 32% compared to the regression model estimation of 34%. Based on the extensive review of all the building block components and validation of PIPPA work by surgeons on the RUC familiar with anesthesia services associated with their specialty, the RUC reached agreement that the revised model predicts anesthesia undervaluation. **The RUC recommends Anesthesia work is undervalued by 32%.**

The RUC also identified three anesthesia services that may be misvalued based on this analysis and recommend that CMS allow review of the base units for at an upcoming RUC meeting:

00142 ***Anesthesia for procedures on eye; lens surgery****
00210 ***Anesthesia for intracranial procedures; not otherwise specified****
00562 ***Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator****
**Assumed to be overvalued, base unit too high or incorrect quintile assumption in the second Five-Year Review valuation.*

<u>Insertion of Heart Pacemaker (Tab P)</u>
Bruce Wikoff, MD, American College of Cardiology (ACC)

During the third Five Year Review, the RUC recommended to increase the work RVUs for the evaluation and management codes, therefore the work RVUs for most procedures with post operative visits were also increased. The Harvard time data included an intensive care day for the single chamber 33207 *Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU 2007 = 9.05) and the RUC surveyed dual chamber procedure 33208 *Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular* (work RVU 2007 = 8.12) does not. When code 33207 was revalued based on the relative values of its post operative visits, its new value reflected a rank order anomaly with 33208 for the 2007 Medicare Physician Fee Schedule. This rank order anomaly was created because physician time of 33208 is based on RUC survey data and 33207 was based on Harvard physician time.

The CMS had recommended that the specialties perform a survey so that the rank order anomaly will be corrected for the 2008 Medicare Physician Fee Schedule.

The RUC reviewed the specialty's survey results and compared the surveyed code to codes 33206 *Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial* (work RVU = 7.31) and 33208 in order to understand the proper rank order between these services. The RUC agreed that the median survey results from 65 cardiologists was appropriate considering their understanding of the different patient populations. The RUC also concurred that patients receiving an atrial lead were quite different than a ventricular, and that the placement of a ventricular lead requires the lead to be placed across the tricuspid valve which adds an additional work component of approximately 0.70 RVUs beyond the work of code 33206. Typical patients receiving atrial pacemaker insertion were considered less risky than those receiving ventrical, and had different medical conditions. The RUC believed that proper rank order would be restored with the recommendation of the survey median of 8.00 work RVUs for CPT code 33207. **The RUC recommends a physician work relative value of 8.00 for code 33207.**

Practice Expense
The RUC recommends no practice expense changes for code 33207.

XII. Direct Practice Expense Input Recommendation – CMS Requests:

Dual Energy X-Ray Absorptiometry (Tab Q)
Geraldine McGinty, MD, American College of Radiology (ACR), Eileen Mynihan, MD, American College of Rheumatology (ACRh), John Siebel, MD, American Academy of Clinical Endocrinologists (AACE), Susan Sherman, MD The Endocrine Society (TES)

In the November 1, 2006 Final Rule, CMS stated, "We received many comments regarding the proposed decrease in PE RVUs for either specific services or for given specialties…. Commenters opposed the proposed decrease in payment for the axial bone density testing (DXA) service, CPT Code 76075 (renumbered to 77080) which is used for detection and quantification of osteoporosis, and CPT codes 76077 (renumbered to 77082), which is used for vertebral fracture assessment. The commenters raised the concern that the proposed decrease in payment for these services would severely restrict patient access to bone density testing thereby undermining our effort to effectively screen Medicare beneficiaries for osteoporosis and vertebral fractures. These commenters identified what they believed to be flaws in the direct input and with the utilization rate applied to the DXA machine. We will request that the RUC review again the practice expense inputs for the DEXA services to ensure that the direct inputs associated with these services are accurately reflected in the database"

AMA staff, accordingly, initiated the Level of Interest Process so that all interested parties would be able to address CMS' request for presentation at the February 2007 RUC meeting. The following specialties provided a joint

recommendation to the PERC and RUC; American College of Rheumatology, The Endocrine Society, The International Society for Clinical Densitometry, American Association of Clinical Endocrinologists, and the American College of Radiology.

The PERC and RUC reviewed and refined the joint specialty recommendation for the direct inputs for codes 77080, 77081, and 77082 during its February and April 2007 meetings. During the RUC review, the RUC discussed and agreed on the following direct practice expense inputs the typical patient scenario. **The RUC recommends the following direct practice expense inputs for CPT codes 77080, 77081, and 77082.**

Cardiac Catheterization (Tab R)
James Maloney, MD, American College of Cardiology (ACC)

In the November 1, 2006 Final Rule, CMS urged specialties to obtain non-facility setting direct cost input data and work with the RUC to develop direct cost input recommendations for 29 cardiac catheterization codes.

At its April 2007 meeting, the RUC developed non-facility direct practice expense inputs for 13 of these codes, and recommends 16 to be non applicable in the non-facility setting. The below table identifies which codes the RUC recommends to be non-applicable in the non-facility setting and those for which the RUC recommends non-facility direct inputs.

CPT Code	Long Descriptor	Global	RUC Recommendation In Non-Facility
93501	Right heart catheterization	000	Direct Inputs Attached
93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	000	Non-applicable
93505	Endomyocardial biopsy	000	Direct Inputs Attached
93508	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization	000	Direct Inputs Attached
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	000	Direct Inputs Attached
93511	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown	000	Non-applicable

CPT Code	Long Descriptor	Global	RUC Recommendation In Non-Facility
93514	Left heart catheterization by left ventricular puncture	000	Non-applicable
93524	Combined transseptal and retrograde left heart catheterization	000	Non-applicable
93526	Combined right heart catheterization and retrograde left heart catheterization	000	Direct Inputs Attached
93527	Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)	000	Non-applicable
93528	Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)	000	Non-applicable
93529	Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)	000	Non-applicable
93530	Right heart catheterization, for congenital cardiac anomalies	000	Non-applicable
93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	000	Non-applicable
93532	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	000	Non-applicable
93533	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	000	Non-applicable
93539	Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass	000	Direct Inputs Attached
93540	Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries	000	Direct Inputs Attached
93541	Injection procedure during cardiac catheterization; for pulmonary angiography	000	Non-applicable
93542	Injection procedure during cardiac	000	Direct Inputs

CPT Code	Long Descriptor	Global	RUC Recommendation In Non-Facility
	catheterization; for selective right ventricular or right atrial angiography		Attached
93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography	000	Direct Inputs Attached
93544	Injection procedure during cardiac catheterization; for aortography	000	Direct Inputs Attached
93545	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	000	Direct Inputs Attached
93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	XXX	Direct Inputs Attached
93556	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)	XXX	Direct Inputs Attached
93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	000	Non-applicable
93562	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output	000	Non-applicable
93571	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)	ZZZ	Non-applicable
93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)	ZZZ	Non-applicable

Transcatheter Placement of an Intravascular Stent(s) (Tab S)
Robert Vogelzang, MD, Society for Interventional Radiology (SIR), American College for Radiology (ACR)

Background:
As the RUC continues to review direct practice expense inputs for new/revised codes, following action by the CPT Editorial Panel. In addition, the Centers for Medicare and Medicaid Services (CMS) forwards sets of previously reviewed CPT codes for the Practice Expense Review Committee (PERC)/RUC to review when new issues arise related to practice costs or specialty societies have requested additional review in their comments/discussion with CMS. The general process following a CMS request is to initiate a level of interest process to determine all interested parties. Codes are then placed on a future PERC agenda for review. In general, these requests have largely focused on missing inputs that were not identified during original review and refinement. However, CMS has also referred codes to the PERC/RUC review if individual physicians or specialties have commented that the services have migrated to the physician office, and there is a need for non-facility direct inputs where there had been none. To date, CMS has not directed the PERC/RUC to derive inputs for the non-facility setting, but simply stated that the PERC/RUC review the specialty recommendations.

At the February 2007 RUC/Practice Expense Subcommittee meeting, members discussed the current PERC processes and agreed that CMS should not infer from PERC recommendations that the PERC (or RUC) approves or endorses a site of service for any particular procedure or service. The PERC is merely providing information as to the resources that typically would be used in a particular setting if the physician chooses to provide the service there. The members believed that it is the physician's choice as to where the patient's care may be best provided and up to CMS and the carriers to determine payment policy. It was agreed that the PERC processes and its relationship with CMS works well and should not be altered at this time.

For the April 2007 RUC meeting SIR and ACR prepared facility and non-facility direct practice expense recommendations for Transcatheter Placement of an Intravascular Stent codes, 37205 and 37206**,** and the associated S&I code 75960. These procedures have historically been typically performed in the facility setting only. The full CPT descriptors are shown below:

37205 - *Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel* (000 Global, Active, Non-Facility PE RVU = 3.77)
37206 - *Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (List*

separately in addition to code for primary procedure) (ZZZ Global, Active, Non-Facility PE RVU = 1.46)
75960 - *Transcatheter introduction of intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel* (XXX Global, Currently Carrier Priced)

Practice Expense
The RUC reviewed the direct practice expense inputs recommended by the specialty society and made several modifications. These modifications were necessary to account for the typical patient who was not consciously sedated.
The RUC recommends the following direct practice expense inputs for codes 37205, 37206, and 75960.

Obstetric/Gynecology – Supply Pack (Tab T)
Society of Gynecologic Oncology (SGO) and the American College of Obstetricians and Gynecologists (ACOG)

The RUC recommends a combination of three medical supply items in order to create a new OB/Gyn Pack.

The RUC recommends combining:
CMS Code SA048 Pack, minimum multi-specialty visit
CMS Code SA051 Pack, pelvic exam
CMS Code SB006 drape, non-sterile sheet 40in x 60in

This new pack would then include the following supplies:

OB/GYN PACK

DESCRIPTION	Code	Unit	Item Qty	Unit price
paper, exam table	SB036	foot	7	0.014
gloves, non-sterile	SB022	pair	2	0.084
gown, patient	SB026	item	1	0.533
pillow case	SB037	item	1	0.307
cover, thermometer probe	SB004	item	1	0.038
drape, non-sterile sheet 40in x 60in	SB006	item	1	0.222
lubricating jelly (K-Y) (5gm uou)	SJ032	item	1	0.066
pad, feminine mini	SK052	item	1	0.110
swab, procto 16 in	SJ052	Item	2	0.117
specula, vaginal	SD118	Item	1	0.540

XIII. HCPAC Review Board (Tab U)

Mary Foto, OTR, iterated the HCPAC meeting discussion to the RUC. Ms. Foto indicated that this was her last meeting as the HCPAC Co-Chair, but that she would still serve on the Review Board as the American Occupational Therapy Association member. Ms. Foto announced that the HCPAC elected Lloyd Smith, DPM as the next HCPAC Co-Chair and Emily H. Hill, PA-C as the Alternate Co-Chair. This first two-year term for Dr. Smith and Ms. Hill will begin in September 2007.

HCPAC Structure and Functions
Ms. Foto indicated that the HCPAC reviewed the HCPAC Structure and Functions document. At the February 2007 meeting when the Non-Physician Team Conference codes were presented, the issue of HCPAC members recusing themselves from voting on a code they have presented arose. The HCPAC determined by a two-thirds vote, that the following will be added to the HCPAC Structure and Functions document under the Processes section: **"Any person who is identified as a presenter, who is also a member of the HCPAC, is prohibited from voting on that code issue presented."**

Audiology and Speech-Language Pathology Services
Ms. Foto informed the RUC that at the HCPAC meeting the American Speech-Language-Hearing Association (ASHA) informed the HCPAC that along with the American Academy of Otolaryngology – Head and Neck Surgeons (AAO-HNS), they would be presenting work relative value recommendations to the RUC and removing audiologists' work from the practice expense inputs. ASHA discussed that they may be bringing forward Speech Pathology codes to the HCPAC in the future to also remove SLPs from the practice expense. However, CMS informed the HCPAC that currently the statute does not allow speech language pathologists to bill Medicare independently.

Relative Value Recommendations for CPT 2008
Ms. Foto indicated that the HCPAC reviewed five new codes, one standard cognitive performance testing code and four non-face-to-face qualified healthcare professional services codes. The full recommendations are attached to these minutes in the HCPAC Review Board Report.

The Health Care Professionals Advisory Committee report was filed and is attached to these minutes.

XIV. Practice Expense Review Committee (Tab V)

Doctor Moran presented the Practice Expense Review Committee report. The PERC spent a significant amount of time reviewing on a large number of codes. Doctor Moran warned staff that they need to increase the level of quality of there

practice expense summary of recommendation forms and the PERC spreadsheets, as many codes were pre-facilitated during the meeting. The PERC will not be pre-facilitating in the future as its time is limited. Doctor Moran stressed the need for PERC standards to be adhered to whenever possible. In addition, all spreadsheets need to be presentable where all codes are displayed so that the PERC may easily review them within the minimum number of pages possible.

Doctor Moran suggested that a PE tutorial for staff since there is on going staff turnover. In addition, Doctor Moran and Doctor Rich indicated that the specialty's physicians need to take responsibility of the contents and formatting of these recommendations. Consistent errors and disregard to the established guidelines will not be acceptable in the future.

The RUC approved the Practice Expense Review Committee report and it is attached to these minutes.

XV. Administrative Subcommittee (Tab W)

Doctor Rich provided the RUC with background on how the RUC arrived at this discussion of reviewing the composition of the RUC. Doctor Rich indicated that MedPAC had several hearings in 2006 discussing the composition of the RUC and the Five-Year Review. MedPAC specifically rejected the concept that the RUC be a representative body, they did not want individuals voting as constituents. MedPAC did indicate that they were concerned regarding the issue of primary care and chronic care and that is why the RUC is examining the RUC's representation of primary/chronic care.

Arthur Traugott, MD, presented the Administrative Subcommittee report to the RUC. Doctor Traugott informed the RUC that Doctor Tuck reiterated that at the February 2007 Administrative Subcommittee meeting the RUC recommended initiating a process of adding a primary care seat to the RUC. AMA staff solicited RUC specialty societies and HCPAC organizations to define the possible primary care seat criteria and eligibility. Doctor Tuck summarized the twenty-five responses received from specialty societies.

Rotating vs. Permanent

The majority of survey responses indicated that the primary care seat be a rotating seat. Based on the input from multiple specialties and detailed discussion, the RUC agreed that the primary care seat be a rotating seat. The RUC agreed that physicians from multiple specialties may be eligible, and it would not be plausible to create a permanent seat. The full RUC will consider the specific individual's expertise in filling the seat and the rotating format will best achieve this intent. The RUC recommends:

The primary care seat should be a rotating seat.

Term and Election Rules
The RUC reviewed the election rules and after a lengthy discussion, determined that the election rules for the primary care seat be the same as the current rotating seat elections. The next rotating seat election is April 2008. The RUC recommends:

The rotating primary care seat will rotate every two years, consistent with current rotating seat policy. (Specialty societies and/or the individual that have been elected to a rotating seat in the previous cycle shall not be eligible for nomination to the four rotating seats for the subsequent cycle (i.e. two years).

The rotating primary care seat election will fall into the same election cycle as the one of the Internal Medicine rotating seats to balance the rotations (e.g., in 2008, the election for the rotating primary care seat and the rotating Internal Medicine seat 1 will occur, subsequently in 2009, the election for the rotating Internal Medicine seat 2 and the rotating "Any Other" rotating seat will occur).

Eligibility of the Individual Candidate
The RUC discussed the eligibility of the individual candidate for the primary care seat, in which RUC members suggested that the candidate eligible for the primary care seat be actively involved in direct patient care. However, the RUC determined to specifically define the eligibility criteria.
The RUC recommends the rotating primary care seat eligibility as follows:

The candidate must be in active clinical practice, with at least 50% of their professional time in direct patient care.

The RUC discussion ensued recommending that the candidate be experienced in chronic disease management (in the solicitation letter, this would be included as a suggestion, not an absolute requirement) and then that the candidate *must* be experienced in disease prevention and chronic disease management. These motions were not approved by the RUC after a representative from ACP requested that this eligibility criteria be instead discussed as part of the definition of primary care.

Definition of Primary Care
The RUC discussed several definitions of primary care, both narrow and broad. The RUC reviewed the current AMA definition of primary care:

> Primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) in a manner that is

> accessible, comprehensive and coordinated by *a licensed MD/DO physician* over time. Care may be provided to an age-specific or gender-specific group of patients, as long as the care of the individual patient meets the above criteria.

The RUC determined that the definition should state qualified health care professional (rather than a licensed MD/DO physician) leaving the opportunity for non-physicians to apply for the seat.

The RUC also discussed adding to the definition of primary care the following: " primary care includes health promotion disease prevention, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings." However, strike the indication of care is limited to those qualified healthcare professionals providing care for gender specific patients. The RUC did not agree with that narrow definition of primary care.

The RUC determined that a broad definition was appropriate, as it would not limit future candidates for this seat as the practice of medicine evolves. The RUC adopted the current AMA primary care definition, with the modification discussed above:

Primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated by a qualified health care professional over time. Care may be provided to an age-specific or gender-specific group of patients, as long as the care of the individual patient meets the above criteria.

Solicitation of Nominations for the Primary Care Seat
The RUC reviewed the current solicitation process for the current rotating seats and recommends that the nominations for rotating seat be solicited from the entire RUC Advisory Committee.

The solicitation letter will be distributed to all specialty societies represented on the RUC Advisory Committee and HCPAC.

The RUC understands that the current *Rotating Seat Policies and Election Rules* already includes a provision to exclude any duplicate nominations for rotating seats. "A specialty society may only be listed once on the ballot, either individually or as part of a coalition." Specialty societies would not be eligible to nominate an individual for more than one rotating seat under consideration.

The RUC requests that the Administrative Subcommittee develop new bylaw language for the RUC's *Structure and Functions* to be considered at the September 2007 RUC meeting. Incorporation of the language for a potential primary care seat will require a two-thirds majority vote of the RUC.

The RUC approved the Administrative Subcommittee report and it is attached to these minutes.

XVI. Practice Expense Subcommittee (Tab Y)

Doctor Moran presented the Practice Expense Subcommittee report for Katherine Bradley, Ph.D. The Subcommittee had the responsibility of providing physician time components for practice expense purposes where only total time exists. Specialties had submitted time components that were reviewed by the subcommittee and discussed via conference call on April 19, 2007.

Subcommittee members had trouble with two codes. One was with CPT code 47564 *Laparoscopy, surgical; cholecystectomy with exploration of common duct* (Work RVU = 14.21), where the data presented was from a RUC survey from1993 that was not approved by the RUC as there were only 11 respondents. Subcommittee members recognized the low response rate from the survey and that the recommended intra-service time was inconsistent with the survey results from 1993. The Subcommittee recommended the intra-service time to be changed to 112 minutes to comply with the established guidelines for physician time allocations.

The other code was CPT code 20979 *Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)* (Work RVU = 0.62). The American Podiatric Medicine Association (APMA) recommended a crosswalk of the physician time components of code 20974 to 20979. Subcommittee members understood that cross-walking physician time components to increase recorded time is not within the established guidelines. The specialty is required to perform a full RUC survey and present the results to this committee if they recommend an increase in time. The Subcommittee recommended the physician time for code 20979 should remain at zero, with the option for the specialty society to conduct a physician time survey to be validated by this committee.

The practice expense subcommittee report was approved by the RUC, the report and spreadsheet of physician time allocation recommendations are attached to these minutes.

The RUC approved the Practice Expense Subcommittee report and it is attached to these minutes.

XVII. Research Subcommittee (Tab Y)

Doctor Cohen presented the Research Subcommittee report to the RUC from the Subcommittee's March 27, 2007 conference call meeting. Doctor Cohen

reviewed the CMS request to review any of the ESRD G-codes, the RPA wishes to present. The Research Subcommittee reviewed the RPA's proposal and recommended that the specialty review the existing language associated with the temporary ESRD G-codes and submit a coding proposal to the CPT Editorial Panel defining these services and typical patients. Further, the Research Subcommittee offered to review vignettes, proposed educational materials and proposed survey instruments at its September 2007 RUC Meeting.

The RUC approved the Research Subcommittee report and it is attached to these minutes.

XVIII. Rotating Seat Elections (Tab Z)

The RUC considered the election of the internal medicine rotating seat. The term for the seat is two years, beginning with the September 2007 RUC meeting and ending in May 2009, with the provision of final recommendations to the Centers for Medicare and Medicaid Services.

The RUC elected Maurits Wiersema, MD, representing the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy.

The RUC considered the election of the "other" rotating seat. The term for the seat is two years, beginning with the September 2007 RUC meeting and ending in May 2009, with the provision of final recommendations to the Centers for Medicare and Medicaid Services.

The RUC elected Samuel Smith, MD, representing the American Society of Pediatric Surgeons.

Doctor Rich noted that the rotating seat terms for both the North American Spine Society and the American Society of Clinical Oncologists will end following the RUC's submission of it recommendations to CMS by May 31, 2007. Doctor Rich and the entire RUC thanked Doctor Charles Mick of NASS and Doctor David Regan of ASCO for their dedicated service to the RUC.

XIX. New Business

Throughout the RUC meeting, a number of referrals were made to subcommittees including:

The RUC recommends that the Administrative Subcommittee review issues surrounding conflict of interest at the RUC. RUC members made the following suggestions:

- **That the RUC review conflict of interest policies for members and attendees, such as significant issues which may be prevalent regarding those attending the meetings (e.g., on-site registration of manufacturer CEO).**
- **The RUC discuss developing a policy for the identification of the individuals and/or consultants who prepare RUC documents. The policy might require all consultants to list the names specialty societies they work for and the names of any corporations they currently work for and have worked for in the past few years. The RUC may choose to create policy that would not allow consultants to solicit information from RUC members during RUC meetings.**
- **The RUC discuss developing a committee to review all conflicts prior to meetings.**
- **The RUC discuss developing a policy so that RUC members may question one's conflict of interest or develop specific criteria for the Chair to rule one's affiliation as appropriate/inappropriate.**
- **The RUC discuss whether to require RUC members to sign the copyright and confidentiality notice, which is currently placed in the front of the agenda books.**

The RUC recommends that the Research Subcommittee review the following issues:

- **The RUC noted that some services that may be performed in both the facility and non-facility setting typically deliver conscious sedation in the non-facility and general anesthesia in the facility. The RUC recommends that the Research Subcommittee consider revising the summary of recommendation questions relating to conscious sedation to identify facility versus non-facility setting in order to differentiate in such settings.**
- **The RUC recommends that the Research Subcommittee consider implications and potential guidelines and policies regarding the validity of surveys where the "Service Performance Rate" is exceptionally low.**

The meeting adjourned on Sunday, April 29, 2007 at 11:00 a.m.

AMA/Specialty Society RVS Update Committee **Tab W**
Administrative Subcommittee Report
April 27, 2007

Members Present: Doctors Richard Tuck (Chair), Michael D. Bishop, James Blankenship, Ronald Burd, Mary Foto, OTR, Peter Hollmann, Barbara Levy, Lawrence Martinelli, Bernard Pfeifer, Susan Spires and Arthur Traugott.

I. Primary Care Seat

Doctor Tuck reiterated that at the February 2007 Administrative Subcommittee meeting the RUC recommended initiating a process of adding a primary care seat to the RUC. AMA staff solicited RUC specialty societies and HCPAC organizations to define the possible primary care seat criteria and eligibility. Doctor Tuck summarized the twenty-five responses received from specialty societies.

Rotating vs. Permanent

The majority of responses indicated that the primary care seat be a rotating seat. Based on the input from multiple specialties and detailed discussion, the Administrative Subcommittee agreed that the primary care seat be a rotating seat. The Subcommittee agreed that physicians from multiple specialties may be eligible, and it would not be plausible to create a permanent seat. The full RUC will consider the specific individual's expertise in filling the seat and the rotating format will best achieve this intent. The RUC recommends:

The primary care seat should be a rotating seat.

Term and Election Rules

The Administrative Subcommittee recommended that the election rules be the same as the current rotating seat elections. The majority of the responding specialties recommended that the term for the primary care rotating seat be two years, consistent with the other three RUC rotating seats. The next rotating seat election is April 2008. The RUC recommends:

The rotating primary care seat will rotate every two years, consistent with current rotating seat policy. (Specialty societies and/or the individual that have been elected to a rotating seat in the previous cycle shall not be eligible for nomination to the four rotating seats for the subsequent cycle (i.e. two years).

The rotating primary care seat election will fall into the same election cycle as the one of the Internal Medicine rotating seats to balance the rotations (e.g., in 2008, the election for the rotating primary care seat and the rotating Internal Medicine seat 1 will occur, subsequently in 2009, the election for the rotating Internal Medicine seat 2 and the rotating "Any Other" rotating seat will occur).

The Administrative Subcommittee discussed a motion to add a sundown provision to the addition of the rotating primary care seat after 8 years. It was argued that this would provide the RUC with the opportunity to assess whether the RUC had achieved its goals by adding a primary care seat. Other Subcommittee members did not feel that this was appropriate and questioned the process and ability to conduct such an assessment. This motion failed.

Eligibility of the Individual Candidate

The RUC recommends the rotating primary care seat eligibility as follows:

The candidate must be in active clinical practice, with at least 50% of their professional time in direct patient care.

The Administrative Subcommittee recommended that the candidate is experienced in chronic disease management. (In the solicitation letter, this would be included as a suggestion, not an absolute requirement). This motion was not approved by the full RUC after a representative from ACP requested that this eligibility criteria be instead discussed as part of the definition of primary care.

The Administrative Subcommittee had noted that the above recommendation related to chronic disease management expertise was a close vote and should be discussed by the full RUC.

Definition of Primary Care
The Administrative Subcommittee discussed several definitions of primary care, both narrow and broad. After a full discussion, the Subcommittee determined that a broad definition was appropriate, as it would not limit future candidates for this seat as the practice of medicine evolves.

The Administrative discussed that the RUC adopt the current AMA definition of primary care:

> Primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated by *a licensed MD/DO physician* over time. Care may be provided to an age-specific or gender-specific group of patients, as long as the care of the individual patient meets the above criteria.

However, the Administrative Subcommittee determined that the definition should state qualified health care professional (rather than a licensed MD/DO physician) leaving the opportunity for non-physicians to apply for the seat.

The RUC adopted the current AMA primary care definition, with the modification discussed above:

> **Primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated by a qualified health care professional over time. Care may be provided to an age-specific or gender-specific group of patients, as long as the care of the individual patient meets the above criteria.**

Solicitation of Nominations for the Primary Care Seat
The Administrative Subcommittee reviewed the current solicitation process for the current rotating seats and recommends that the nominations for rotating seat be solicited from a the entire RUC Advisory Committee.

> **The solicitation letter will be distributed to all specialty societies represented on the RUC Advisory Committee and HCPAC.**

The Administrative Subcommittee understands that the current *Rotating Seat Policies and Election Rules* already includes a provision to exclude any duplicate nominations for rotating seats. "A specialty society may only be listed once on the ballot, either individually or as part of a coalition." Specialty societies would not be eligible to nominate an individual for more than one rotating seat under consideration.

The RUC requests that the Administrative Subcommittee develop new bylaw language for the RUC's *Structure and Functions* to be considered at the September 2007 RUC meeting. Incorporation of the language for a potential primary care seat will require a two-thirds majority vote of the RUC.

II. Review of Rotating Seat Elections

Doctor Tuck reviewed the rotating seat election policies to prepare the Administrative Subcommittee for the upcoming Internal Medicine rotating seat and "any other" rotating seat elections at this meeting. The Administrative Subcommittee did not have any questions or concerns regarding the submitted nominations.

Workgroup Validated Model

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3	00322	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; needle biopsy of thyroid (For procedures on cervical spine and cord, see 00600, 00604, 00670)			0.45	0.17	0.14	0.67	1.43	10.00	102.74	92.7	0.031	2.875	4.305	3.602	157	**(19.51%)**
3	00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	93.61	83.6	0.031	2.592	4.022	3.379	430992	**(19.01%)**
3	00454	Anesthesia for procedures on clavicle and scapula; biopsy of clavicle			0.45	0.17	0.14	0.67	1.43	10.00	89.00	79.0	0.031	2.449	3.879	3.267	251	**(18.73%)**
3	00640	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine			0.45	0.17	0.14	0.67	1.43	10.00	114.07	104.1	0.031	3.226	4.656	3.878	3855	**(20.06%)**
3	00910	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified	X		0.45	0.17	0.14	0.67	1.43	10.00	72.72	62.7	0.031	1.944	3.374	2.870	362980	**(17.57%)**
3	00920	Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	99.65	89.7	0.031	2.779	4.209	3.527	44862	**(19.35%)**
3	00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral			0.45	0.17	0.14	0.67	1.43	10.00	85.41	75.4	0.031	2.338	3.768	3.180	179	**(18.50%)**
3	00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified (For anesthesia for abortion procedures, see 01965 or 01966)			0.45	0.17	0.14	0.67	1.43	10.00	78.97	69.0	0.031	2.138	3.568	3.022	50214	**(18.05%)**
3	01130	Anesthesia for body cast application or revision			0.45	0.17	0.14	0.67	1.43	10.00	129.78	119.8	0.031	3.713	5.143	4.261	48	**(20.69%)**
3	01180	Anesthesia for obturator neurectomy; extrapelvic			0.45	0.17	0.14	0.67	1.43	10.00	141.16	131.2	0.031	4.066	5.496	4.539	27	**(21.09%)**
3	01260	Anesthesia for all procedures involving veins of upper leg, including exploration			0.45	0.17	0.14	0.67	1.43	10.00	123.85	113.8	0.031	3.529	4.959	4.117	10665	**(20.47%)**
3	01380	Anesthesia for all closed procedures on knee joint			0.45	0.17	0.14	0.67	1.43	10.00	56.97	47.0	0.031	1.456	2.886	2.486	9740	**(16.09%)**
3	01382	Anesthesia for diagnostic arthroscopic procedures of knee joint	X		0.45	0.17	0.14	0.67	1.43	10.00	92.03	82.0	0.031	2.543	3.973	3.341	40923	**(18.92%)**
3	01390	Anesthesia for all closed procedures on upper ends of tibia, fibula, and/or patella			0.45	0.17	0.14	0.67	1.43	10.00	98.85	88.9	0.031	2.754	4.184	3.507	1298	**(19.31%)**
3	01420	Anesthesia for all cast applications, removal, or repair involving knee joint			0.45	0.17	0.14	0.67	1.43	10.00	107.57	97.6	0.031	3.025	4.455	3.720	404	**(19.76%)**
3	01430	Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	139.57	129.6	0.031	4.017	5.447	4.500	341	**(21.04%)**
3	01462	Anesthesia for all closed procedures on lower leg, ankle, and foot			0.45	0.17	0.14	0.67	1.43	10.00	93.19	83.2	0.031	2.579	4.009	3.369	8243	**(18.99%)**
3	01464	Anesthesia for arthroscopic procedures of ankle and/or foot			0.45	0.17	0.14	0.67	1.43	10.00	108.94	98.9	0.031	3.067	4.497	3.753	3517	**(19.82%)**

Workgroup Validated Model

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3	01470	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	94.24	84.2	0.031	2.611	4.041	3.395	67066	**(19.05%)**
3	01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	115.25	105.2	0.031	3.263	4.693	3.907	232179	**(20.11%)**
3	01490	Anesthesia for lower leg cast application, removal, or repair			0.45	0.17	0.14	0.67	1.43	10.00	81.79	71.8	0.031	2.225	3.655	3.091	250	**(18.25%)**
3	01520	Anesthesia for procedures on veins of lower leg; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	125.59	115.6	0.031	3.583	5.013	4.159	6294	**(20.54%)**
3	01680	Anesthesia for shoulder cast application, removal or repair; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	108.35	98.3	0.031	3.049	4.479	3.739	47	**(19.79%)**
3	01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	99.74	89.7	0.031	2.782	4.212	3.529	14037	**(19.36%)**
3	01730	Anesthesia for all closed procedures on humerus and elbow			0.45	0.17	0.14	0.67	1.43	10.00	98.50	88.5	0.031	2.744	4.174	3.499	2696	**(19.29%)**
3	01732	Anesthesia for diagnostic arthroscopic procedures of elbow joint			0.45	0.17	0.14	0.67	1.43	10.00	119.08	109.1	0.031	3.382	4.812	4.000	192	**(20.27%)**
3	01780	Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	136.03	126.0	0.031	3.907	5.337	4.414	1689	**(20.92%)**
3	01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand			0.45	0.17	0.14	0.67	1.43	10.00	80.43	70.4	0.031	2.183	3.613	3.058	248994	**(18.16%)**
3	01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones			0.45	0.17	0.14	0.67	1.43	10.00	85.79	75.8	0.031	2.350	3.780	3.189	28342	**(18.52%)**
3	01829	Anesthesia for diagnostic arthroscopic procedures on the wrist			0.45	0.17	0.14	0.67	1.43	10.00	131.20	121.2	0.031	3.757	5.187	4.296	226	**(20.75%)**
3	01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified (Includes open procedures on bones of the hand)			0.45	0.17	0.14	0.67	1.43	10.00	119.92	109.9	0.031	3.408	4.838	4.021	74791	**(20.31%)**
3	01850	Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified			0.45	0.17	0.14	0.67	1.43	10.00	97.79	87.8	0.031	2.721	4.151	3.481	3106	**(19.25%)**
3	01860	Anesthesia for forearm, wrist, or hand cast application, removal, or repair			0.45	0.17	0.14	0.67	1.43	10.00	96.72	86.7	0.031	2.688	4.118	3.455	200	**(19.19%)**
3	01951	Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than four percent total body surface area			0.45	0.17	0.14	0.67	1.43	10.00	98.41	88.4	0.031	2.741	4.171	3.496	848	**(19.28%)**

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3	01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position			0.45	0.17	0.14	0.67	1.43	10.00	56.54	46.5	0.031	1.443	2.873	2.476	24061	**(16.04%)**
3	01996	Daily hospital management of epidural or subarachnoid continuous drug administration (Report code 01996 for daily hospital management of continuous epidural or subarachnoid drug administration performed after insertion of an epidural or subarachnoid cath			0.45	0.17	0.14	0.67	1.43	10.00	0.00	-10.0	0.031	-0.310	1.120	1.097	305322	**--**
4	00104	Anesthesia for electroconvulsive therapy			0.67	0.76	0.21	0.80	2.44	9.00	47.02	38.0	0.033	1.262	3.702	2.609	185622	**(41.87%)**
4	00124	Anesthesia for procedures on external, middle, and inner ear including biopsy; otoscopy			0.67	0.76	0.21	0.80	2.44	9.00	66.58	57.6	0.033	1.911	4.351	3.086	740	**(40.98%)**
4	00126	Anesthesia for procedures on external, middle, and inner ear including biopsy; tympanotomy (Includes tympanostomy)			0.67	0.76	0.21	0.80	2.44	9.00	59.09	50.1	0.033	1.662	4.102	2.903	8587	**(41.28%)**
4	00142	Anesthesia for procedures on eye; lens surgery	X		0.67	0.17	0.14	0.40	1.38	9.00	57.51	48.5	0.033	1.610	2.992	2.865	2164280	**(4.43%)**
4	00147	Anesthesia for procedures on eye; iridectomy			0.67	0.76	0.21	0.80	2.44	9.00	92.91	83.9	0.033	2.785	5.225	3.728	1292	**(40.14%)**
4	00148	Anesthesia for procedures on eye; ophthalmoscopy			0.67	0.76	0.21	0.80	2.44	9.00	62.75	53.8	0.033	1.784	4.224	2.993	945	**(41.13%)**
4	00164	Anesthesia for procedures on nose and accessory sinuses; biopsy, soft tissue			0.67	0.76	0.21	0.80	2.44	9.00	94.30	85.3	0.033	2.831	5.271	3.762	687	**(40.10%)**
4	00410	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; electrical conversion of arrhythmias			0.67	0.76	0.21	0.80	2.44	9.00	179.99	171.0	0.033	5.674	8.114	5.851	57923	**(38.68%)**
4	00522	Anesthesia for closed chest procedures; needle biopsy of pleura			0.67	0.76	0.21	0.80	2.44	9.00	108.89	99.9	0.033	3.315	5.755	4.118	953	**(39.76%)**
4	00524	Anesthesia for closed chest procedures; pneumocentesis			0.67	0.76	0.21	0.80	2.44	9.00	89.75	80.7	0.033	2.680	5.120	3.651	1166	**(40.23%)**
4	00530	Anesthesia for permanent transvenous pacemaker insertion (This code also to be used for anesthesia for replacement or testing of permanent transvenous pacemaker)			0.67	0.76	0.21	0.80	2.44	9.00	115.26	106.3	0.033	3.526	5.966	4.273	108613	**(39.63%)**
4	00532	Anesthesia for access to central venous circulation			0.67	0.76	0.21	0.80	2.44	9.00	90.61	81.6	0.033	2.708	5.148	3.672	209333	**(40.20%)**
4	00635	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture			0.67	0.76	0.21	0.80	2.44	9.00	61.28	52.3	0.033	1.735	4.175	2.957	5003	**(41.19%)**
4	00700	Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified			0.67	0.76	0.21	0.80	2.44	9.00	103.55	94.5	0.033	3.138	5.578	3.987	9422	**(39.88%)**
4	00702	Anesthesia for procedures on upper anterior abdominal wall; percutaneous liver biopsy			0.67	0.76	0.21	0.80	2.44	9.00	92.79	83.8	0.033	2.780	5.220	3.725	1567	**(40.14%)**
4	00750	Anesthesia for hernia repairs in upper abdomen; not otherwise specified			0.67	0.76	0.21	0.80	2.44	9.00	103.03	94.0	0.033	3.120	5.560	3.975	28056	**(39.89%)**
4	00800	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified			0.67	0.76	0.21	0.80	2.44	9.00	95.09	86.1	0.033	2.857	5.297	3.781	26162	**(40.08%)**

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4	00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified	X		0.88	0.76	0.21	0.80	2.65	9.00	113.46	104.5	0.033	3.466	6.120	4.229	177297	**(44.72%)**
4	00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis			0.67	0.76	0.21	0.80	2.44	9.00	174.41	165.4	0.033	5.489	7.929	5.715	45	**(38.74%)**
4	00906	Anesthesia for vulvectomy			0.67	0.76	0.21	0.80	2.44	9.00	110.71	101.7	0.033	3.375	5.815	4.162	2430	**(39.72%)**
4	00924	Anesthesia for procedures on male genitalia (including open urethral procedures); undescended testis, unilateral or bilateral			0.67	0.76	0.21	0.80	2.44	9.00	116.76	107.8	0.033	3.576	6.016	4.310	66	**(39.60%)**
4	00926	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, inguinal			0.67	0.76	0.21	0.80	2.44	9.00	105.70	96.7	0.033	3.209	5.649	4.040	1934	**(39.83%)**
4	00930	Anesthesia for procedures on male genitalia (including open urethral procedures); orchiopexy, unilateral or bilateral			0.67	0.76	0.21	0.80	2.44	9.00	102.48	93.5	0.033	3.102	5.542	3.961	508	**(39.90%)**
4	00932	Anesthesia for procedures on male genitalia (including open urethral procedures); complete amputation of penis			0.67	0.76	0.21	0.80	2.44	9.00	152.55	143.5	0.033	4.764	7.204	5.182	161	**(39.01%)**
4	00938	Anesthesia for procedures on male genitalia (including open urethral procedures); insertion of penile prosthesis (perineal approach)			0.67	0.76	0.21	0.80	2.44	9.00	152.93	143.9	0.033	4.776	7.216	5.192	9173	**(39.00%)**
4	00942	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); colpotomy, vaginectomy, colporrhaphy, and open urethral procedures			0.67	0.76	0.21	0.80	2.44	9.00	129.81	120.8	0.033	4.009	6.449	4.628	35435	**(39.36%)**
4	00948	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); cervical cerclage			0.67	0.76	0.21	0.80	2.44	9.00	92.18	83.2	0.033	2.760	5.200	3.710	249	**(40.16%)**
4	00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography (Includes uterine brachytherapy)			0.67	0.76	0.21	0.80	2.44	9.00	78.08	69.1	0.033	2.292	4.732	3.367	52704	**(40.57%)**
4	01160	Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint			0.67	0.76	0.21	0.80	2.44	9.00	55.01	46.0	0.033	1.527	3.967	2.804	2157	**(41.47%)**
4	01190	Anesthesia for obturator neurectomy; intrapelvic			0.67	0.76	0.21	0.80	2.44	9.00	129.97	121.0	0.033	4.014	6.454	4.632	11	**(39.35%)**
4	01200	Anesthesia for all closed procedures involving hip joint			0.67	0.76	0.21	0.80	2.44	9.00	67.32	58.3	0.033	1.935	4.375	3.104	20748	**(40.95%)**
4	01202	Anesthesia for arthroscopic procedures of hip joint			0.67	0.76	0.21	0.80	2.44	9.00	145.46	136.5	0.033	4.528	6.968	5.009	856	**(39.11%)**
4	01220	Anesthesia for all closed procedures involving upper 2/3 of femur			0.67	0.76	0.21	0.80	2.44	9.00	113.82	104.8	0.033	3.479	5.919	4.238	15634	**(39.66%)**
4	01250	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg			0.67	0.76	0.21	0.80	2.44	9.00	103.88	94.9	0.033	3.149	5.589	3.996	14599	**(39.87%)**
4	01272	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery ligation			0.67	0.76	0.21	0.80	2.44	9.00	134.62	125.6	0.033	4.169	6.609	4.745	372	**(39.28%)**

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4	01320	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of knee and/or popliteal area			0.67	0.76	0.21	0.80	2.44	9.00	106.40	97.4	0.033	3.232	5.672	4.057	12432	**(39.81%)**
4	01340	Anesthesia for all closed procedures on lower 1/3 of femur			0.67	0.76	0.21	0.80	2.44	9.00	117.56	108.6	0.033	3.603	6.043	4.329	1372	**(39.58%)**
4	01392	Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella			0.67	0.76	0.21	0.80	2.44	9.00	139.96	131.0	0.033	4.346	6.786	4.875	16105	**(39.19%)**
4	01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified			0.67	0.76	0.21	0.80	2.44	9.00	95.64	86.6	0.033	2.875	5.315	3.795	170895	**(40.07%)**
4	01482	Anesthesia for open procedures on bones of lower leg, ankle, and foot; radical resection (including below knee amputation)			0.67	0.76	0.21	0.80	2.44	9.00	125.46	116.5	0.033	3.865	6.305	4.522	32671	**(39.43%)**
4	01484	Anesthesia for open procedures on bones of lower leg, ankle, and foot; osteotomy or osteoplasty of tibia and/or fibula			0.67	0.76	0.21	0.80	2.44	9.00	158.36	149.4	0.033	4.957	7.397	5.324	3990	**(38.93%)**
4	01620	Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint			0.67	0.76	0.21	0.80	2.44	9.00	69.60	60.6	0.033	2.011	4.451	3.160	9542	**(40.87%)**
4	01622	Anesthesia for diagnostic arthroscopic procedures of shoulder joint			0.67	0.76	0.21	0.80	2.44	9.00	145.20	136.2	0.033	4.520	6.960	5.003	11424	**(39.11%)**
4	01670	Anesthesia for all procedures on veins of shoulder and axilla			0.67	0.76	0.21	0.80	2.44	9.00	128.60	119.6	0.033	3.969	6.409	4.598	599	**(39.38%)**
4	01682	Anesthesia for shoulder cast application, removal or repair; shoulder spica			0.67	0.76	0.21	0.80	2.44	9.00	109.16	100.2	0.033	3.324	5.764	4.124	4	**(39.75%)**
4	01740	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified			0.67	0.76	0.21	0.80	2.44	9.00	144.23	135.2	0.033	4.488	6.928	4.979	22294	**(39.13%)**
4	01782	Anesthesia for procedures on veins of upper arm and elbow; phleborrhaphy			0.67	0.76	0.21	0.80	2.44	9.00	159.81	150.8	0.033	5.005	7.445	5.359	254	**(38.91%)**
4	01852	Anesthesia for procedures on veins of forearm, wrist, and hand; phleborrhaphy			0.67	0.76	0.21	0.80	2.44	9.00	107.91	98.9	0.033	3.282	5.722	4.094	16	**(39.78%)**
4	01965	Anesthesia for incomplete or missed abortion procedures			0.67	0.76	0.21	0.80	2.44	9.00	0.00	-9.0	0.033	-0.299	2.141	1.463	0	**0.00%**
4	01966	Anesthesia for induced abortion procedures			0.67	0.76	0.21	0.80	2.44	9.00	0.00	-9.0	0.033	-0.299	2.141	1.463	0	**0.00%**
5	00100	Anesthesia for procedures on salivary glands, including biopsy			0.88	0.76	0.21	0.84	2.69	12.50	165.00	152.5	0.035	5.394	8.084	5.851	14235	**(38.15%)**
5	00103	Anesthesia for reconstructive procedures of eyelid, (eg, blepharoplasty, ptosis surgery)			0.88	0.76	0.21	0.84	2.69	12.50	93.37	80.9	0.035	2.860	5.550	4.105	70969	**(35.21%)**
5	00120	Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	131.78	119.3	0.035	4.219	6.909	5.041	23886	**(37.04%)**
5	00140	Anesthesia for procedures on eye; not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	90.11	77.6	0.035	2.745	5.435	4.025	160949	**(35.01%)**
5	00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	113.44	100.9	0.035	3.570	6.260	4.594	67393	**(36.26%)**
5	00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	105.74	93.2	0.035	3.298	5.988	4.407	32011	**(35.88%)**

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5	00190	Anesthesia for procedures on facial bones or skull; not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	135.80	123.3	0.035	4.361	7.051	5.140	10949	**(37.20%)**
5	00212	Anesthesia for intracranial procedures; subdural taps			0.88	0.76	0.21	0.84	2.69	12.50	114.19	101.7	0.035	3.597	6.287	4.613	207	**(36.30%)**
5	00300	Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	107.87	95.4	0.035	3.373	6.063	4.459	201357	**(35.99%)**
5	00352	Anesthesia for procedures on major vessels of neck; simple ligation (For radiologic procedure, see codes 01905 through 01933)			0.88	0.76	0.21	0.84	2.69	12.50	182.56	170.1	0.035	6.015	8.705	6.280	16819	**(38.63%)**
5	00402	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps)			0.88	0.76	0.21	0.84	2.69	12.50	90.93	78.4	0.035	2.774	5.464	4.046	18974	**(35.06%)**
5	00404	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast	X		0.88	0.76	0.14	0.67	2.45	12.50	175.49	163.0	0.035	5.765	8.215	6.107	45506	**(34.51%)**
5	00450	Anesthesia for procedures on clavicle and scapula; not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	124.29	111.8	0.035	3.954	6.644	4.859	3953	**(36.74%)**
5	00730	Anesthesia for procedures on upper posterior abdominal wall			0.88	0.76	0.21	0.84	2.69	12.50	108.42	95.9	0.035	3.393	6.083	4.472	6538	**(36.02%)**
5	00740	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum			0.88	0.76	0.21	0.84	2.69	12.50	62.54	50.0	0.035	1.770	4.460	3.353	589551	**(33.00%)**
5	00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy			0.88	0.76	0.21	0.84	2.69	12.50	197.88	185.4	0.035	6.557	9.247	6.653	1783	**(38.99%)**
5	00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum (For endoscopic procedures limited to the anus and rectum, see code 00902)			0.88	0.76	0.21	0.84	2.69	12.50	61.66	49.2	0.035	1.739	4.429	3.332	814951	**(32.92%)**
5	00820	Anesthesia for procedures on lower posterior abdominal wall			0.88	0.76	0.21	0.84	2.69	12.50	100.56	88.1	0.035	3.115	5.805	4.280	7168	**(35.61%)**
5	00834	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, under 1 year of age (Do not report 00834 in conjunction with code 99100)			0.88	0.76	0.21	0.84	2.69	12.50	128.36	115.9	0.035	4.098	6.788	4.958	133	**(36.91%)**
5	00870	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; cystolithotomy			0.88	0.76	0.21	0.84	2.69	12.50	109.46	97.0	0.035	3.430	6.120	4.497	1551	**(36.07%)**
5	00873	Anesthesia for lithotripsy, extracorporeal shock wave; without water bath			0.88	0.76	0.21	0.84	2.69	12.50	92.19	79.7	0.035	2.819	5.509	4.076	52452	**(35.14%)**
5	00902	Anesthesia for anorectal procedure (Including anorectal endoscopy and/or biopsy)			0.88	0.76	0.21	0.84	2.69	12.50	87.57	75.1	0.035	2.655	5.345	3.964	117247	**(34.86%)**

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5	00912	Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of bladder tumor(s)			0.88	0.76	0.21	0.84	2.69	12.50	90.65	78.2	0.035	2.764	5.454	4.039	115774	**(35.05%)**
5	00914	Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate	X		0.88	0.76	0.21	1.01	2.86	12.50	117.36	104.9	0.035	3.709	6.564	4.690	122180	**(39.96%)**
5	00916	Anesthesia for transurethral procedures (including urethrocystoscopy); post-transurethral resection bleeding			0.88	0.76	0.21	0.84	2.69	12.50	106.70	94.2	0.035	3.332	6.022	4.430	1519	**(35.93%)**
5	00918	Anesthesia for transurethral procedures (including urethrocystoscopy); with fragmentation, manipulation and/or removal of ureteral calculus			0.88	0.76	0.21	0.84	2.69	12.50	104.97	92.5	0.035	3.271	5.961	4.388	46400	**(35.85%)**
5	00950	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy			0.88	0.76	0.21	0.84	2.69	12.50	97.34	84.8	0.035	3.001	5.691	4.202	116	**(35.44%)**
5	01112	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest (May report code 01112 when bone graft obtained from iliac crest)			0.88	0.76	0.21	0.84	2.69	12.50	68.89	56.4	0.035	1.994	4.684	3.508	4844	**(33.53%)**
5	01232	Anesthesia for open procedures involving upper 2/3 of femur; amputation			0.88	0.76	0.21	0.84	2.69	12.50	126.51	114.0	0.035	4.033	6.723	4.913	33433	**(36.83%)**
5	01360	Anesthesia for all open procedures on lower 1/3 of femur			0.88	0.76	0.21	0.84	2.69	12.50	151.74	139.2	0.035	4.925	7.615	5.528	14504	**(37.75%)**
5	01404	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee			0.88	0.76	0.21	0.84	2.69	12.50	132.64	120.1	0.035	4.249	6.939	5.063	2165	**(37.08%)**
5	01472	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; repair of ruptured Achilles tendon, with or without graft			0.88	0.76	0.21	0.84	2.69	12.50	133.82	121.3	0.035	4.291	6.981	5.091	3144	**(37.12%)**
5	01474	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; gastrocnemius recession (eg, Strayer procedure)			0.88	0.76	0.21	0.84	2.69	12.50	153.08	140.6	0.035	4.972	7.662	5.561	869	**(37.79%)**
5	01522	Anesthesia for procedures on veins of lower leg; venous thrombectomy, direct or with catheter			0.88	0.76	0.21	0.84	2.69	12.50	155.38	142.9	0.035	5.054	7.744	5.617	1333	**(37.86%)**
5	01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla			0.88	0.76	0.21	0.84	2.69	12.50	130.43	117.9	0.035	4.171	6.861	5.009	73353	**(36.99%)**
5	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	148.21	135.7	0.035	4.800	7.490	5.442	121031	**(37.63%)**

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5	01712	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenotomy, elbow to shoulder, open			0.88	0.76	0.21	0.84	2.69	12.50	113.30	100.8	0.035	3.565	6.255	4.591	73	**(36.25%)**
5	01714	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenoplasty, elbow to shoulder			0.88	0.76	0.21	0.84	2.69	12.50	153.32	140.8	0.035	4.981	7.671	5.567	46	**(37.80%)**
5	01716	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenodesis, rupture of long tendon of biceps			0.88	0.76	0.21	0.84	2.69	12.50	139.95	127.4	0.035	4.508	7.198	5.241	363	**(37.35%)**
5	01742	Anesthesia for open or surgical arthroscopic procedures of the elbow; osteotomy of humerus			0.88	0.76	0.21	0.84	2.69	12.50	163.81	151.3	0.035	5.352	8.042	5.822	230	**(38.12%)**
5	01744	Anesthesia for open or surgical arthroscopic procedures of the elbow; repair of nonunion or malunion of humerus (Includes repair of humeral shaft fractures)			0.88	0.76	0.21	0.84	2.69	12.50	181.92	169.4	0.035	5.993	8.683	6.264	3649	**(38.61%)**
5	01758	Anesthesia for open or surgical arthroscopic procedures of the elbow; excision of cyst or tumor of humerus			0.88	0.76	0.21	0.84	2.69	12.50	111.89	99.4	0.035	3.515	6.205	4.557	324	**(36.19%)**
5	01905	Anesthesia for myelography, diskography, vertebroplasty (Includes percutaneous vertebral augmentation)			0.88	0.76	0.21	0.84	2.69	12.50	115.31	102.8	0.035	3.636	6.326	4.640	17442	**(36.35%)**
5	01916	Anesthesia for diagnostic arteriography/venography			0.88	0.76	0.21	0.84	2.69	12.50	139.65	127.1	0.035	4.497	7.187	5.233	25209	**(37.34%)**
5	01924	Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	149.73	137.2	0.035	4.854	7.544	5.479	16687	**(37.68%)**
5	01930	Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified			0.88	0.76	0.21	0.84	2.69	12.50	98.51	86.0	0.035	3.042	5.732	4.230	6411	**(35.50%)**
5	01952	Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between four and nine percent of total body surface area			0.88	0.76	0.21	0.84	2.69	12.50	146.91	134.4	0.035	4.754	7.444	5.410	973	**(37.59%)**
5	01958	Anesthesia for external cephalic version procedure			0.88	0.76	0.21	0.84	2.69	12.50	0.00	-12.5	0.035	-0.442	2.248	1.829	0	**0.00%**
5	01960	Anesthesia for vaginal delivery only (Report code 01960 only when the patient has not received any labor analgesia/anesthesia care. Do not report code 01960 in conjunction with code 01967.)			0.88	0.76	0.21	0.84	2.69	12.50	223.82	211.3	0.035	7.474	10.164	7.285	196	**(39.52%)**

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5	01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor) (Time units reported according to local sta			0.88	0.76	0.21	0.84	2.69	12.50	266.71	254.2	0.035	8.992	11.682	8.331	3989	**(40.21%)**
5	01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) (Use 01969 in conjunction with code 01967) (Time units reported as for surgical anesthesia services)			0.88	0.76	0.21	0.84	2.69	12.50	0.00	-12.5	0.035	-0.442	2.248	1.829	0	**0.00%**
5	01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position			0.88	0.76	0.21	0.84	2.69	12.50	53.55	41.1	0.035	1.452	4.142	3.134	117025	**(32.15%)**
5	01995	Regional intravenous administration of local anesthetic agent or other medication (upper or lower extremity)			0.88	0.76	0.21	0.84	2.69	12.50	122.72	110.2	0.035	3.898	6.588	4.821	1733	**(36.67%)**
6	00102	Anesthesia for procedures involving plastic repair of cleft lip			0.88	0.76	0.21	1.12	2.97	17.80	132.36	114.6	0.038	4.302	7.272	5.421	82	**(34.14%)**
6	00144	Anesthesia for procedures on eye; corneal transplant			0.88	0.76	0.21	1.12	2.97	17.80	119.77	102.0	0.038	3.829	6.799	5.114	20272	**(32.95%)**
6	00145	Anesthesia for procedures on eye; vitreoretinal surgery			0.88	0.76	0.21	1.12	2.97	17.80	119.62	101.8	0.038	3.824	6.794	5.111	124326	**(32.93%)**
6	00172	Anesthesia for intraoral procedures, including biopsy; repair of cleft palate			0.88	0.76	0.21	1.12	2.97	17.80	142.90	125.1	0.038	4.698	7.668	5.678	109	**(35.04%)**
6	00174	Anesthesia for intraoral procedures, including biopsy; excision of retropharyngeal tumor			0.88	0.76	0.21	1.12	2.97	17.80	123.21	105.4	0.038	3.959	6.929	5.198	108	**(33.29%)**
6	00222	Anesthesia for intracranial procedures; electrocoagulation of intracranial nerve			0.88	0.76	0.21	1.12	2.97	17.80	102.78	85.0	0.038	3.192	6.162	4.700	820	**(31.09%)**
6	00320	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older			0.88	0.76	0.21	1.12	2.97	17.80	118.39	100.6	0.038	3.778	6.748	5.081	173597	**(32.81%)**
6	00452	Anesthesia for procedures on clavicle and scapula; radical surgery			0.88	0.76	0.21	1.12	2.97	17.80	150.21	132.4	0.038	4.973	7.943	5.856	101	**(35.62%)**
6	00470	Anesthesia for partial rib resection; not otherwise specified			0.88	0.76	0.21	1.12	2.97	17.80	125.05	107.3	0.038	4.028	6.998	5.243	2009	**(33.47%)**
6	00520	Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified (For transvenous pacemaker insertion, see 00530)			0.88	0.76	0.21	1.12	2.97	17.80	83.34	65.5	0.038	2.461	5.431	4.226	59348	**(28.52%)**

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6	00752	Anesthesia for hernia repairs in upper abdomen; lumbar and ventral (incisional) hernias and/or wound dehiscence			0.88	0.76	0.21	1.12	2.97	17.80	133.61	115.8	0.038	4.349	7.319	5.452	33165	**(34.25%)**
6	00832	Anesthesia for hernia repairs in lower abdomen; ventral and incisional hernias			0.88	0.76	0.21	1.12	2.97	17.80	130.96	113.2	0.038	4.250	7.220	5.387	39674	**(34.02%)**
6	00836	Anesthesia for hernia repairs in the lower abdomen not otherwise specified, infants less than 37 weeks gestational age at birth and less than 50 weeks gestational age at time of surgery (Do not report 00836 in conjunction with code 99100)			0.88	0.76	0.21	1.12	2.97	17.80	132.21	114.4	0.038	4.297	7.267	5.418	84	**(34.13%)**
6	00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified	X		0.88	0.76	0.21	1.21	3.06	17.80	159.77	142.0	0.038	5.332	8.388	6.090	331729	**(37.74%)**
6	00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection			0.88	0.76	0.21	1.12	2.97	17.80	95.91	78.1	0.038	2.933	5.903	4.533	2009	**(30.24%)**
6	00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified			0.88	0.76	0.21	1.12	2.97	17.80	132.64	114.8	0.038	4.313	7.283	5.428	70528	**(34.17%)**
6	00908	Anesthesia for perineal prostatectomy			0.88	0.76	0.21	1.12	2.97	17.80	193.96	176.2	0.038	6.616	9.586	6.923	708	**(38.46%)**
6	00922	Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vesicles			0.88	0.76	0.21	1.12	2.97	17.80	108.91	91.1	0.038	3.422	6.392	4.850	144	**(31.80%)**
6	00928	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, abdominal			0.88	0.76	0.21	1.12	2.97	17.80	115.49	97.7	0.038	3.669	6.639	5.010	134	**(32.51%)**
6	00934	Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal lymphadenectomy			0.88	0.76	0.21	1.12	2.97	17.80	257.17	239.4	0.038	8.990	11.960	8.464	41	**(41.29%)**
6	00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy	X		0.88	0.76	0.20	1.01	2.84	17.80	175.04	157.2	0.038	5.905	8.746	6.462	26626	**(35.35%)**
6	01120	Anesthesia for procedures on bony pelvis			0.88	0.76	0.21	1.12	2.97	17.80	96.28	78.5	0.038	2.947	5.917	4.542	5752	**(30.29%)**
6	01210	Anesthesia for open procedures involving hip joint; not otherwise specified			0.88	0.76	0.21	1.12	2.97	17.80	148.67	130.9	0.038	4.915	7.885	5.819	106688	**(35.50%)**
6	01230	Anesthesia for open procedures involving upper 2/3 of femur; not otherwise specified	X		1.50	0.76	0.21	1.34	3.81	17.80	143.61	125.8	0.038	4.725	8.535	5.696	189939	**(49.85%)**
6	01274	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery embolectomy			0.88	0.76	0.21	1.12	2.97	17.80	172.98	155.2	0.038	5.828	8.798	6.412	12586	**(37.22%)**
6	01432	Anesthesia for procedures on veins of knee and popliteal area; arteriovenous fistula			0.88	0.76	0.21	1.12	2.97	17.80	151.13	133.3	0.038	5.007	7.977	5.879	427	**(35.69%)**

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6	01502	Anesthesia for procedures on arteries of lower leg, including bypass graft; embolectomy, direct or with catheter			0.88	0.76	0.21	1.12	2.97	17.80	168.86	151.1	0.038	5.673	8.643	6.311	1266	**(36.95%)**
6	01632	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; radical resection			0.88	0.76	0.21	1.12	2.97	17.80	179.81	162.0	0.038	6.084	9.054	6.578	403	**(37.64%)**
6	01650	Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified			0.88	0.76	0.21	1.12	2.97	17.80	140.21	122.4	0.038	4.597	7.567	5.613	2026	**(34.82%)**
6	01756	Anesthesia for open or surgical arthroscopic procedures of the elbow; radical procedures (Includes amputation and limb salvage procedures on the upper arm)			0.88	0.76	0.21	1.12	2.97	17.80	140.85	123.0	0.038	4.621	7.591	5.628	673	**(34.87%)**
6	01770	Anesthesia for procedures on arteries of upper arm and elbow; not otherwise specified (For dialysis access procedures, see code 01844)			0.88	0.76	0.21	1.12	2.97	17.80	148.70	130.9	0.038	4.916	7.886	5.820	14919	**(35.50%)**
6	01772	Anesthesia for procedures on arteries of upper arm and elbow; embolectomy			0.88	0.76	0.21	1.12	2.97	17.80	129.22	111.4	0.038	4.184	7.154	5.345	4280	**(33.86%)**
6	01832	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; total wrist replacement			0.88	0.76	0.21	1.12	2.97	17.80	175.27	157.5	0.038	5.914	8.884	6.468	228	**(37.36%)**
6	01840	Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified			0.88	0.76	0.21	1.12	2.97	17.80	146.66	128.9	0.038	4.839	7.809	5.770	4258	**(35.34%)**
6	01842	Anesthesia for procedures on arteries of forearm, wrist, and hand; embolectomy			0.88	0.76	0.21	1.12	2.97	17.80	130.78	113.0	0.038	4.243	7.213	5.383	1378	**(34.00%)**
6	01844	Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis)	X		0.88	0.76	0.21	0.92	2.77	17.80	138.33	120.5	0.038	4.527	7.295	5.567	205724	**(31.03%)**
6	01932	Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular			0.88	0.76	0.21	1.12	2.97	17.80	117.78	100.0	0.038	3.755	6.725	5.066	221	**(32.75%)**
7	00162	Anesthesia for procedures on nose and accessory sinuses; radical surgery			0.88	0.76	0.21	1.12	2.97	17.80	159.35	141.6	0.040	5.625	8.595	6.445	2116	**(33.36%)**
7	00176	Anesthesia for intraoral procedures, including biopsy; radical surgery			0.88	0.76	0.21	1.12	2.97	17.80	306.83	289.0	0.040	11.486	14.456	10.041	1838	**(43.97%)**
7	00192	Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism)			0.88	0.76	0.21	1.12	2.97	17.80	202.45	184.7	0.040	7.338	10.308	7.496	2226	**(37.52%)**
7	00326	Anesthesia for all procedures on the larynx and trachea in children less than 1 year of age (Except tracheobronchial reconstruction) (Do not report 00326 in conjunction with code 99100)			0.88	0.76	0.21	1.12	2.97	17.80	0.00	-17.8	0.040	-0.707	2.263	2.560	107	**--**

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7	00534	Anesthesia for transvenous insertion or replacement of pacing cardioverter/defibrillator (This code includes anesthetic management for testing of pacing cardioverter-defibrillator)			0.88	0.76	0.21	1.12	2.97	17.80	143.10	125.3	0.040	4.979	7.949	6.049	39192	**(31.42%)**
7	00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation			0.88	0.76	0.21	1.12	2.97	17.80	136.69	118.9	0.040	4.725	7.695	5.893	25362	**(30.58%)**
7	00632	Anesthesia for procedures in lumbar region; lumbar sympathectomy			0.88	0.76	0.21	1.12	2.97	17.80	131.30	113.5	0.040	4.511	7.481	5.761	470	**(29.84%)**
7	00754	Anesthesia for hernia repairs in upper abdomen; omphalocele			0.88	0.76	0.21	1.12	2.97	17.80	141.53	123.7	0.040	4.917	7.887	6.011	160	**(31.22%)**
7	00756	Anesthesia for hernia repairs in upper abdomen; transabdominal repair of diaphragmatic hernia			0.88	0.76	0.21	1.12	2.97	17.80	203.19	185.4	0.040	7.367	10.337	7.514	472	**(37.58%)**
7	00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	X		1.00	0.76	0.21	1.01	2.98	17.80	158.82	141.0	0.040	5.604	8.579	6.432	512760	**(33.38%)**
7	00844	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; abdominoperineal resection			0.88	0.76	0.21	1.12	2.97	17.80	243.97	226.2	0.040	8.988	11.958	8.508	8146	**(40.55%)**
7	00862	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper 1/3 of ureter, or donor nephrectomy			0.88	0.76	0.21	1.12	2.97	17.80	214.69	196.9	0.040	7.825	10.795	7.794	41037	**(38.49%)**
7	00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)			0.88	0.76	0.21	1.12	2.97	17.80	230.70	212.9	0.040	8.461	11.431	8.185	23147	**(39.66%)**
7	00872	Anesthesia for lithotripsy, extracorporeal shock wave; with water bath			0.88	0.76	0.21	1.12	2.97	17.80	110.40	92.6	0.040	3.680	6.650	5.252	10489	**(26.63%)**
7	00904	Anesthesia for radical perineal procedure			0.88	0.76	0.21	1.12	2.97	17.80	192.25	174.5	0.040	6.933	9.903	7.247	6000	**(36.64%)**
7	01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	X		0.88	0.76	0.21	1.21	3.06	17.80	173.63	155.8	0.040	6.193	9.249	6.793	355168	**(36.15%)**
7	01486	Anesthesia for open procedures on bones of lower leg, ankle, and foot; total ankle replacement			0.88	0.76	0.21	1.12	2.97	17.80	220.74	202.9	0.040	8.065	11.035	7.942	931	**(38.95%)**
7	01760	Anesthesia for open or surgical arthroscopic procedures of the elbow; total elbow replacement			0.88	0.76	0.21	1.12	2.97	17.80	223.68	205.9	0.040	8.182	11.152	8.014	1210	**(39.16%)**
7	01920	Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)			0.88	0.76	0.21	1.12	2.97	17.80	97.95	80.2	0.040	3.185	6.155	4.948	8653	**(24.40%)**
7	01922	Anesthesia for non-invasive imaging or radiation therapy (Report code 01922 when the medical imaging is the primary service, an integral component of a therapeutic service not otherwise reportable or when it increases the complexity of the anesthesia care			0.88	0.76	0.21	1.12	2.97	17.80	111.05	93.3	0.040	3.706	6.676	5.268	44746	**(26.74%)**

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7	01925	Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; carotid or coronary			0.88	0.76	0.21	1.12	2.97	17.80	118.64	100.8	0.040	4.007	6.977	5.453	5050	**(27.97%)**
7	01931	Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (eg, transcutaneous porto-caval shunt (TIPS))			0.88	0.76	0.21	1.12	2.97	17.80	188.67	170.9	0.040	6.790	9.760	7.160	1797	**(36.32%)**
7	01933	Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial			0.88	0.76	0.21	1.12	2.97	17.80	206.14	188.3	0.040	7.485	10.455	7.586	196	**(37.82%)**
7	01961	Anesthesia for cesarean delivery only (Report code 01961 only when the patient has not received any labor analgesia/anesthesia care. Do not report code 01961 in conjunction with code 01967.)			0.88	0.76	0.21	1.12	2.97	17.80	117.65	99.9	0.040	3.968	6.938	5.429	4432	**(27.81%)**
7	01990	Physiological support for harvesting of organ(s) from brain-dead patient			0.88	0.76	0.21	1.12	2.97	17.80	212.99	195.2	0.040	7.757	10.727	7.753	216	**(38.36%)**
8	00528	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy not utilizing one lung ventilation			0.88	0.76	0.21	1.12	2.97	17.80	130.32	112.5	0.042	4.718	7.688	6.103	19110	**(25.96%)**
8	00630	Anesthesia for procedures in lumbar region; not otherwise specified	X		0.88	0.76	0.21	1.01	2.86	17.80	162.62	144.8	0.042	6.072	8.927	6.890	202721	**(29.55%)**
8	00794	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; pancreatectomy, partial or total (eg, Whipple procedure)			0.88	0.76	0.21	1.12	2.97	17.80	320.47	302.7	0.042	12.690	15.660	10.739	6261	**(45.82%)**
8	00846	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy			0.88	0.76	0.21	1.12	2.97	17.80	205.32	187.5	0.042	7.862	10.832	7.932	7846	**(36.57%)**
8	00848	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration			0.88	0.76	0.21	1.12	2.97	17.80	330.09	312.3	0.042	13.093	16.063	10.974	597	**(46.38%)**
8	00864	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; total cystectomy			0.88	0.76	0.21	1.12	2.97	17.80	343.82	326.0	0.042	13.669	16.639	11.308	6304	**(47.14%)**
8	00936	Anesthesia for procedures on male genitalia (including open urethral procedures); radical amputation of penis with bilateral inguinal and iliac lymphadenectomy			0.88	0.76	0.21	1.12	2.97	17.80	225.17	207.4	0.042	8.694	11.664	8.416	26	**(38.60%)**
8	01170	Anesthesia for open procedures involving symphysis pubis or sacroiliac joint			0.88	0.76	0.21	1.12	2.97	17.80	154.89	137.1	0.042	5.748	8.718	6.702	996	**(30.07%)**
8	01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty			0.88	0.76	0.21	1.12	2.97	17.80	177.30	159.5	0.042	6.687	9.657	7.249	182564	**(33.23%)**

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8	01234	Anesthesia for open procedures involving upper 2/3 of femur; radical resection			0.88	0.76	0.21	1.12	2.97	17.80	165.28	147.5	0.042	6.183	9.153	6.955	473	**(31.60%)**
8	01270	Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified (For dialysis access procedures, see code 01844)	X		0.88	0.76	0.21	1.34	3.19	17.80	227.77	210.0	0.042	8.803	11.993	8.479	86883	**(41.45%)**
8	01440	Anesthesia for procedures on arteries of knee and popliteal area; not otherwise specified			0.88	0.76	0.21	1.12	2.97	17.80	218.41	200.6	0.042	8.411	11.381	8.251	1844	**(37.94%)**
8	01442	Anesthesia for procedures on arteries of knee and popliteal area; popliteal thromboendarterectomy, with or without patch graft			0.88	0.76	0.21	1.12	2.97	17.80	210.37	192.6	0.042	8.074	11.044	8.055	1284	**(37.11%)**
8	01444	Anesthesia for procedures on arteries of knee and popliteal area; popliteal excision and graft or repair for occlusion or aneurysm			0.88	0.76	0.21	1.12	2.97	17.80	255.11	237.3	0.042	9.949	12.919	9.145	4264	**(41.26%)**
8	01500	Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified			0.88	0.76	0.21	1.12	2.97	17.80	225.61	207.8	0.042	8.712	11.682	8.426	3504	**(38.64%)**
8	01654	Anesthesia for procedures on arteries of shoulder and axilla; bypass graft			0.88	0.76	0.21	1.12	2.97	17.80	212.56	194.8	0.042	8.166	11.136	8.108	512	**(37.34%)**
8	01926	Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic			0.88	0.76	0.21	1.12	2.97	17.80	228.39	210.6	0.042	8.829	11.799	8.494	15050	**(38.91%)**
8	01962	Anesthesia for urgent hysterectomy following delivery			0.88	0.76	0.21	1.12	2.97	17.80	254.88	237.1	0.042	9.940	12.910	9.140	59	**(41.25%)**
8	01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care			0.88	0.76	0.21	1.12	2.97	17.80	153.54	135.7	0.042	5.691	8.661	6.669	47	**(29.87%)**
9	00214	Anesthesia for intracranial procedures; burr holes, including ventriculography			0.88	0.76	0.21	1.12	2.97	17.80	128.29	110.5	0.044	4.874	7.844	6.419	12332	**(22.19%)**
9	00215	Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)			0.88	0.76	0.21	1.12	2.97	17.80	157.75	140.0	0.044	6.174	9.144	7.138	843	**(28.10%)**
9	01634	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation			0.88	0.76	0.21	1.12	2.97	17.80	185.39	167.6	0.044	7.393	10.363	7.811	77	**(32.66%)**
10	00220	Anesthesia for intracranial procedures; cerebrospinal fluid shunting procedures			0.88	0.76	0.21	1.12	2.97	17.80	139.75	122.0	0.046	5.646	8.616	7.064	12695	**(21.96%)**
10	00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	X		0.88	0.76	0.27	1.34	3.25	17.80	107.60	89.8	0.046	4.158	7.404	6.281	125824	**(17.88%)**
10	00472	Anesthesia for partial rib resection; thoracoplasty (any type)			0.88	0.76	0.21	1.12	2.97	17.80	181.67	163.9	0.046	7.587	10.557	8.087	367	**(30.55%)**
10	00550	Anesthesia for sternal debridement			0.88	0.76	0.21	1.12	2.97	17.80	156.45	138.7	0.046	6.419	9.389	7.472	7239	**(25.66%)**

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10	00600	Anesthesia for procedures on cervical spine and cord; not otherwise specified (For myelography and diskography, see radiological procedures 01905)			0.88	0.76	0.21	1.12	2.97	17.80	195.17	177.4	0.046	8.212	11.182	8.416	40246	**(32.87%)**
10	00620	Anesthesia for procedures on thoracic spine and cord; not otherwise specified			0.88	0.76	0.21	1.12	2.97	17.80	162.40	144.6	0.046	6.694	9.664	7.617	16410	**(26.89%)**
10	00634	Anesthesia for procedures in lumbar region; chemonucleolysis			0.88	0.76	0.21	1.12	2.97	17.80	72.68	54.9	0.046	2.541	5.511	5.429	40	**(1.50%)**
10	00866	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; adrenalectomy			0.88	0.76	0.21	1.12	2.97	17.80	223.32	205.5	0.046	9.515	12.485	9.102	1451	**(37.17%)**
10	00868	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal transplant (recipient) (For donor nephrectomy, use 00862) (For harvesting kidney from brain-dead patient, use 01990)			0.88	0.76	0.21	1.12	2.97	17.80	252.91	235.1	0.046	10.885	13.855	9.823	11299	**(41.04%)**
10	00882	Anesthesia for procedures on major lower abdominal vessels; inferior vena cava ligation			0.88	0.76	0.21	1.12	2.97	17.80	98.28	80.5	0.046	3.726	6.696	6.053	13754	**(10.62%)**
10	01150	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation			0.88	0.76	0.21	1.12	2.97	17.80	219.14	201.3	0.046	9.321	12.291	9.000	407	**(36.57%)**
10	01212	Anesthesia for open procedures involving hip joint; hip disarticulation			0.88	0.76	0.21	1.12	2.97	17.80	216.38	198.6	0.046	9.194	12.164	8.933	525	**(36.17%)**
10	01215	Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty			0.88	0.76	0.21	1.12	2.97	17.80	220.96	203.2	0.046	9.405	12.375	9.044	28884	**(36.83%)**
10	01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement			0.88	0.76	0.21	1.12	2.97	17.80	203.67	185.9	0.046	8.605	11.575	8.623	16889	**(34.24%)**
10	01652	Anesthesia for procedures on arteries of shoulder and axilla; axillary-brachial aneurysm			0.88	0.76	0.21	1.12	2.97	17.80	154.96	137.2	0.046	6.350	9.320	7.435	820	**(25.35%)**
10	01656	Anesthesia for procedures on arteries of shoulder and axilla; axillary-femoral bypass graft			0.88	0.76	0.21	1.12	2.97	17.80	275.48	257.7	0.046	11.930	14.900	10.374	2428	**(43.63%)**
11	00210	Anesthesia for intracranial procedures; not otherwise specified	X		0.88	1.08	0.28	1.34	3.58	17.80	224.63	206.8	0.048	10.027	13.602	9.499	42127	**(43.19%)**
11	00529	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation			0.88	0.76	0.21	1.12	2.97	17.80	158.59	140.8	0.048	6.826	9.796	7.889	3583	**(24.16%)**
11	00797	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity			0.88	0.76	0.21	1.12	2.97	17.80	204.83	187.0	0.048	9.068	12.038	9.017	11709	**(33.50%)**

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12	00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified (For diagnostic thoracoscopy use code 00528 or 00529. For surgical thoracoscopy use code 00540 or 00541)	X		0.88	0.76	0.28	2.01	3.93	17.80	193.84	176.0	0.051	8.919	12.849	9.115	35088	**(40.98%)**
12	01173	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum			0.88	0.76	0.21	1.12	2.97	17.80	193.49	175.7	0.051	8.902	11.872	9.106	1295	**(30.37%)**
13	00218	Anesthesia for intracranial procedures; procedures in sitting position			0.88	0.76	0.21	1.34	3.19	30.00	236.73	206.7	0.053	10.926	14.116	10.526	3865	**(34.11%)**
13	00406	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast with internal mammary node dissection			0.88	0.76	0.21	1.34	3.19	30.00	148.63	118.6	0.053	6.270	9.460	8.378	1313	**(12.91%)**
13	00474	Anesthesia for partial rib resection; radical procedures (eg, pectus excavatum) (For sternal wire removal, see code 00470)			0.88	0.76	0.21	1.34	3.19	30.00	211.95	182.0	0.053	9.616	12.806	9.922	300	**(29.07%)**
13	00604	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position			0.88	0.76	0.21	1.34	3.19	30.00	197.92	167.9	0.053	8.875	12.065	9.580	833	**(25.94%)**
13	00622	Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy			0.88	0.76	0.21	1.34	3.19	30.00	212.88	182.9	0.053	9.665	12.855	9.944	39	**(29.27%)**
13	00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)			0.88	0.76	0.21	1.34	3.19	30.00	276.61	246.6	0.053	13.034	16.224	11.498	64585	**(41.10%)**
13	00792	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of liver hemorrhage (excluding liver biopsy)			0.88	0.76	0.21	1.34	3.19	30.00	261.09	231.1	0.053	12.214	15.404	11.120	3456	**(38.52%)**
15	00216	Anesthesia for intracranial procedures; vascular procedures			0.88	0.76	0.28	1.34	3.26	30.00	278.15	248.2	0.057	14.200	17.460	12.267	4506	**(42.33%)**
15	00500	Anesthesia for all procedures on esophagus		X	0.88	0.76	0.28	2.01	3.93	30.00	303.70	273.7	0.057	15.661	19.591	12.890	4946	**(51.99%)**
15	00541	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation		X	0.88	0.76	0.28	2.01	3.93	30.00	213.40	183.4	0.057	10.495	14.425	10.689	31442	**(34.95%)**
15	00542	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); decortication		X	0.88	0.76	0.28	2.01	3.93	30.00	189.13	159.1	0.057	9.106	13.036	10.097	8696	**(29.11%)**

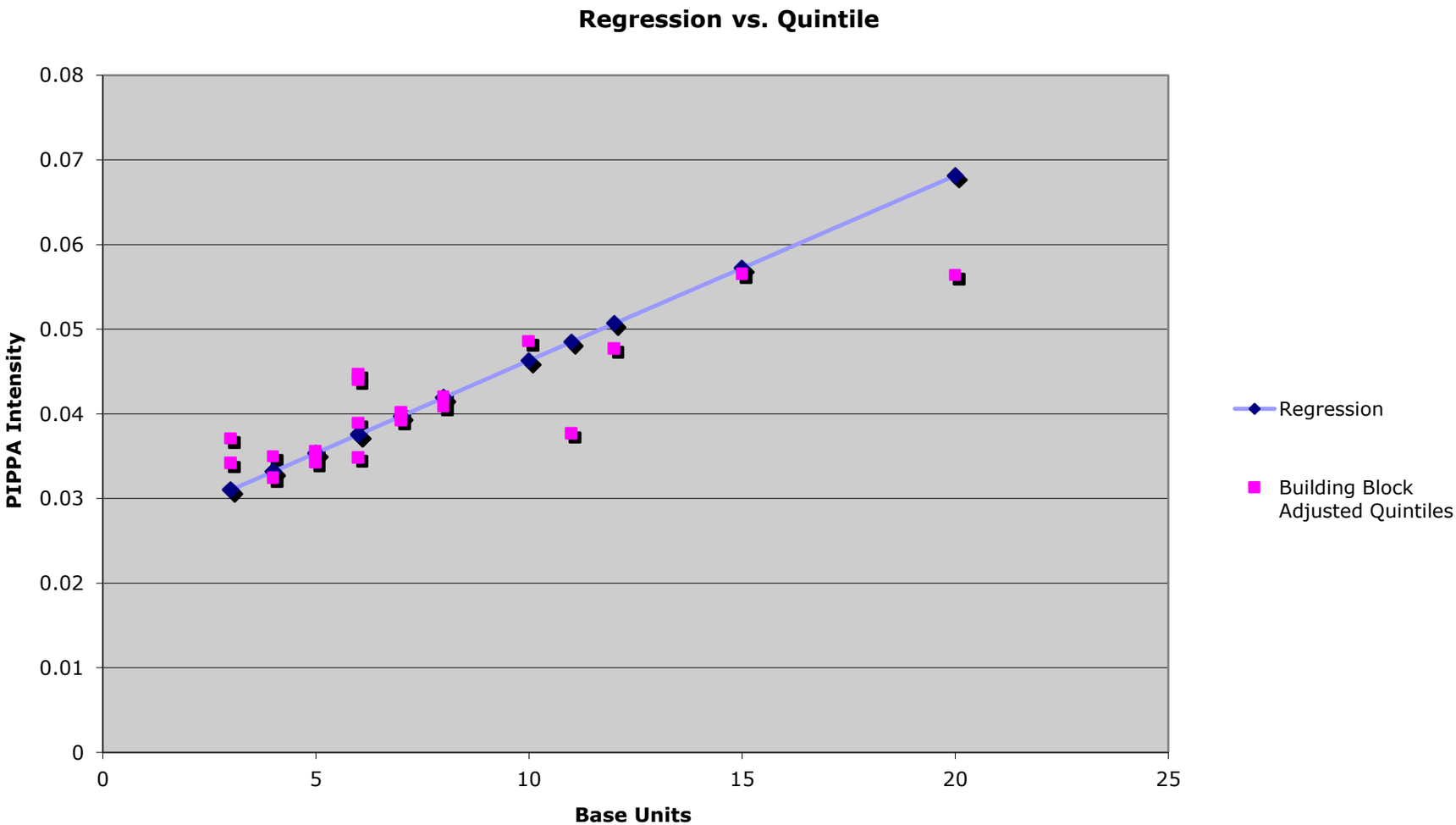
Workgroup Validated Model

Base Units	CPT	Descriptor	Index Codes	One Lung Ventilation	Building block Pre Work	Building Block Post work	Building Block Prep work	Building Block IPP work	Total non PIPPA Building block work	Building Block IPP time	CMS Time	Building Block PIPPA Time	PIPPA Intensity	Building Block PIPPA Work	Building Block Total Work	Imputed Work	Volume	% Imputed Work Undervalued compared to Building Block
15	00546	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty		X	0.88	0.76	0.28	2.01	3.93	30.00	251.28	221.3	0.057	12.662	16.592	11.612	605	**(42.89%)**
15	00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator			0.88	0.76	0.28	1.34	3.26	30.00	181.64	151.6	0.057	8.677	11.937	9.914	25013	**(20.40%)**
15	00770	Anesthesia for all procedures on major abdominal blood vessels	X		0.88	0.76	0.28	1.34	3.26	30.00	266.28	236.3	0.057	13.521	16.781	11.978	32923	**(40.10%)**
15	00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified			0.88	0.76	0.28	1.34	3.26	30.00	275.35	245.4	0.057	14.040	17.300	12.199	17220	**(41.81%)**
15	01140	Anesthesia for interpelviabdominal (hindquarter) amputation			0.88	0.76	0.28	1.34	3.26	30.00	237.27	207.3	0.057	11.861	15.121	11.271	74	**(34.16%)**
15	01636	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; interthoracoscapular (forequarter) amputation			0.88	0.76	0.28	1.34	3.26	30.00	218.08	188.1	0.057	10.762	14.022	10.803	44	**(29.80%)**
17	00548	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); intrathoracic procedures on the trachea and bronchi (For tracheobronchial reconstruction, see code 00539.)		X	1.50	1.08	0.28	2.01	4.87	30.00	225.39	195.4	0.062	12.035	16.905	11.712	322	**(44.33%)**
18	00539	Anesthesia for tracheobronchial reconstruction (For procedures other than reconstruction, see code 00548)		X	1.50	1.08	0.28	2.01	4.87	30.00	265.60	235.6	0.064	15.026	19.896	13.059	151	**(52.36%)**
20	00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator	X		1.50	1.08	0.28	1.68	4.53	25.00	264.00	239.0	0.068	16.287	20.817	13.751	191129	**(51.39%)**
20	00580	Anesthesia for heart transplant or heart/lung transplant			1.50	1.08	0.28	2.01	4.87	25.00	453.54	428.5	0.068	29.204	34.074	18.372	1064	**(85.47%)**
25	00561	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, under one year of age (Do not report 00561 in conjunction with 99100, 99116, and 99135)			1.50	1.08	0.28	2.01	4.87	25.00	0.00	-25.0	0.079	-1.977	2.893	9.143	0	**0.00%**
25	00563	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest			1.50	1.08	0.28	2.01	4.87	25.00	0.00	-25.0	0.079	-1.977	2.893	9.143	8120	**--**
25	00566	Anesthesia for direct coronary artery bypass grafting without pump oxygenator			1.50	1.08	0.28	2.01	4.87	25.00	0.00	-25.0	0.079	-1.977	2.893	9.143	27506	**--**
30	00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient) (For harvesting of liver, use 01990)			1.50	1.08	0.28	2.01	4.87	25.00	497.90	472.9	0.090	42.561	47.431	23.111	1411	**(105.23%)**
																	TOTAL	**(32.00%)**

Level	Intensity-Linear Distribution	Intensity-Maintain Proportions from 2000 Five Year Review	2000 Five Year Review Intensities	Distribution
L1	0.031	0.031	0.0224	0.00%
L2	0.044	0.039	0.031	13.74%
L3	0.055	0.058	0.051	45.69%
L4	0.070	0.076	0.07	76.04%
L5	0.090	0.090	0.085	100.00%

Base Unit	ASA Code	Normalized L1	Normalized L2	Normalized L3	Normalized L4	Normalized L5	PIPPA Time	Regression Intensity	Aggregate Quintile Intensity	Intensity Difference	Work difference	Volume	PIPPA Vol Adj Work Diff
3	00910	34.1	9.0	9.0	0.0	0.0	52	0.031	0.037	-0.006	-0.31	362980	-114098
3	01382	60.2	4.9	6.9	0.0	0.0	72	0.031	0.034	-0.003	-0.23	40923	-9252
4	00142	47.8	10.2	0.0	0.0	0.0	58	0.033	0.032	0.001	0.04	2164280	95801
4	00830	67.4	9.8	9.8	0.0	0.0	87	0.033	0.035	-0.002	-0.15	177297	-27059
5	00404	87.0	10.0	10.0	0.0	0.0	107	0.035	0.034	0.001	0.12	45506	5325
5	00914	56.5	14.1	9.4	0.0	0.0	80	0.035	0.036	0.000	-0.02	122180	-2260
6	00840	56.1	31.5	29.6	14.8	0.0	132	0.038	0.044	-0.006	-0.85	331729	-281855
6	00944	77.0	15.0	10.0	0.0	0.0	102	0.038	0.035	0.003	0.28	26626	7390
6	01230	30.0	30.0	20.0	10.0	0.0	90	0.038	0.045	-0.007	-0.64	189939	-121731
6	01844	61.4	30.7	10.2	7.7	0.0	110	0.038	0.039	-0.001	-0.15	205724	-30411
7	00790	46.8	20.6	20.6	0.0	0.0	88	0.040	0.039	0.001	0.05	512760	24340
7	01402	73.8	28.2	20.7	9.4	0.0	132	0.040	0.040	0.000	-0.05	355168	-18930
8	00630	60.7	26.8	25.3	10.1	0.0	123	0.042	0.042	0.000	-0.01	202721	-2012
8	01270	66.3	28.1	20.4	10.2	0.0	125	0.042	0.041	0.001	0.13	86883	11330
10	00350	32.8	36.5	36.5	21.3	0.0	127	0.046	0.049	-0.002	-0.29	125824	-36463
11	00210	144.3	33.8	23.7	11.3	0.0	213	0.048	0.038	0.011	2.31	42127	97144
12	00540	44.3	33.2	27.7	22.1	2.8	130	0.051	0.048	0.003	0.39	35088	13550
15	00770	37.0	40.0	40.0	30.0	30.0	177	0.057	0.057	0.001	0.12	32923	4050
20	00562	50.6	60.7	38.8	50.6	38.2	239	0.068	0.056	0.012	2.81	191129	537735

Net Volume Weighted Regression Estimated Over/(Under) Estimation of PIPPA RVW	152595
Net Payment Difference due to Over/(Under) Estimation of PIPPA Work	$5,782,960
Net Estimation Error as % of Allowed Charges for the 19 Index Codes	0.7%
Level 2 Intensity Needed to Create No Net Estimation Error	0.0406


Regression vs. Quintile
PIPPA Intensity
0.08
0.07
0.06
0.05
0.04
0.03
0.02
0.01
0
0
5
10
15
20
25
Base Units
Regression
Building Block Adjusted Quintiles

AMA/Specialty Society RVS Update Committee **Tab O**
Anesthesia Workgroup
April 26, 2007

Members Present: Doctors Daniel Mark Siegel (Chair), David Hitzeman, Leonard Lichtenfeld, James Regan, Chad Rubin, Peter Smith and Richard Tuck.

Review of Anesthesia Services
The Anesthesia Workgroup convened to consider the request from CMS to assign Post-Induction Period Procedure Anesthesia (PIPPA) intensity. In addition, CMS referred to the RUC the question of how and whether to apply the E/M update to anesthesia procedures. *See Federal Register/Vol. 71, No. 231/December 1, 2006 page 69733.*

Conference Call, March 1, 2007
The Workgroup convened two conference calls, March 1 and April 19, 2007. On the first call, ASA explained the CMS correspondence to date and the undervaluation of anesthesia services. ASA presented a linear regression model to expand upon the work performed in the second Five-Year Review. The ASA analysis was referenced in the CMS request in the summer of 2006.

ASA maintained the following:
1. The previous workgroup had established fair and reasonable inputs for most elements of the building block presented in the second Five-Year Review.
2. ASA contended that the aggregate intensities in the post-induction period from the previous analysis were flawed.
3. RUC actions between the second and third Five-Year Review established relevant benchmarks for considering anesthesia work.

On this call, ASA presented the regression model and entertained questions from the Workgroup. Additionally, ASA engaged an independent economist to review their model for statistical validity. Michael O'Grady, PhD, was present on the first call and answered questions by the workgroup. After discussion, the Workgroup suggested that:
1. ASA consider methods to demonstrate the validity that all elements of Anesthesia work increases in anesthesia base units.
2. Medicare frequency and charge information be used to extend the number of services considered in their review.
3. AMA obtain a second review of the methodology by an AMA staff economist.

Second Conference Call, April 19, 2007
- ASA presented data obtained between the first two calls to provide additional evidence to support the relationship between base units and anesthesia work.
- ASA surveyed an expert panel to determine the elements of work present in the post-induction period for the 19 originally studied codes and several additional codes as well. The results of this survey demonstrated a fairly linear relationship between the number of elements and the base unit values assigned to those services.
- ASA summarized their points of agreement and disagreement with the previous analysis. ASA agreed with all of the previous allocations except the post-induction period aggregate intensities.
- The workgroup briefly discussed the analysis prepared by AMA economist, Kurt Gillis, PhD. Dr. Gillis suggested that a review of additional services may improve the predictive power of the model. Dr. Gillis also discussed the importance of assigning correct intensities for the floor and ceiling of the regression model as these have significant impact of the results of the model.
- The specific charge from CMS to the RUC was to review the range of intensities in the PIPPA period.

The workgroup requested that ASA perform the following tasks for presentation at the Anesthesia Workgroup April 2007 RUC meeting:
1. Expand the list of codes being reviewed to encompass at least 70% of all allowed Medicare charges for anesthesia services.
2. Compare the PIPPA intensity regression to a retrofitted result from the quintile time allocations developed in the second Five-Year Review using the new proposed intensities.

3. Workgroup requested that the economists be available at the Workgroup session to answer any questions on the regression analysis.

April 26, 2007 Anesthesia Workgroup Meeting
The Anesthesia Workgroup met three times during the April 2007 RUC meeting to consider the additional information provided by ASA in detail.

ASA provided all the building block elements for the additional codes requested using regression to predict pre-, post-, prep, induction period procedure work and the PIPPA work. These codes along with the original 19 codes, account for 81% of all Medicare allowed charges for the anesthesia code set.

The ASA presented the retrofitted data, which demonstrated a 0.7% difference between the regression model of PIPPA work and the quintile model of work.

The Workgroup reviewed the additional codes and determined that rather than using regression for the non-PIPPA work elements, a bottom-up building block approach be used to determine values for the non-PIPPA work independent of the regression model. E/M proxies for the pre and post work would be appropriate values for the pre- and post-work. The Workgroup selected E/M levels of service consistent with the assignments made during the second Five-Year Review. The levels of E/M services increased in base unit ranges. The Workgroup assigned work values for the prep work and induction period procedure work consistent with the work values used in the second Five-Year Review. Like the E/M equivalents, these values did increase with higher base units. Additionally, the Workgroup considered the special circumstance of one-lung ventilation in several of the anesthesia codes and recommend an increased value for those services. The Workgroup recommends that where the building block values differed from the original 19 codes, the original values be used.

Pre-Anesthesia Time
The base units were referenced to the same E/M services by base unit range, as was previously performed in the second Five-Year Review building block.

- Codes with a base unit of 3 are referenced to 99201 (work RVU=0.45);
- Codes with a base unit of 4 are referenced to blend of 99201/99202 (work RVU=0.67);
- Codes with a base unit of 5-15 are referenced to 99202 (work RVU=0.88); and
- Codes with a base unit of 16-30 are referenced to code 99252 (work RVU=1.50).

Preparation Time
The equipment and supply preparation time was linked to the original 19 codes reviewed in the 2nd Five Year Review and carried throughout each of the additional codes per base unit.

- Codes with a base unit of 3 are assigned an RVU of 0.14
- Codes with base units 4-14 are assigned 0.21
- Codes with base units 15-30 are assigned 0.28

Induction Period
The induction period is calculated based on the survey data of the original 19 codes. The RVU component per base unit varied based on survey data, therefore the Workgroup took the average RVUs of each base unit segment of the previous 19 codes.

- Codes with a base unit of 3 = 0.67
- Codes with base unit of 4 = 0.80
- Codes with base unit of 5 = 0.84
- Codes with base unit of base unit 6-12 = 1.12
- Codes with base units of 13-19 = 1.34
- Codes with base units of base unit 20-30 = 2.01 (two-lung vent cases are at 1.34) In the special circumstance of one-lung ventilation due to the increased work involved in this situation, these codes were assigned an IPP

work value of 2.01. A total of 6 codes out of more than 270 anesthesia codes involve one lung ventilation typically, representing 0.37% of Medicare allowed charges.

Post-Induction Period Procedure Anesthesia (PIPPA)
The Workgroup recognized that regression was a necessary element for calculating PIPPA work for codes other than the original 19 which used a quintile intensity model to determine work, which was reviewed and validated extensively by the second Five-Year Review workgroup. The Workgroup was satisfied that the retrofitted quintile data proved that regression accurately predicts PIPPA work. The Workgroup discussed the floor and ceiling proposed by ASA for the regression, and agreed that the floor could be no less than 0.031 and a ceiling of 0.090 was reasonable. The rationale supporting the range includes:

1. The RUC has previously approved and reaffirmed that moderate sedation maintenance performed by a second provider, CPT code 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*, has an intensity of 0.031. The Workgroup determined that this was a reasonable floor for anesthesia PIPPA. Additional codes supporting this rationale includes: 50391 *Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)* intensity 0.043 and code 90760 *Intravenous infusion, hydration; initial, up to 1 hour,* intensity 0.031.
2. For the ceiling, the workgroup agreed that for the most highly valued service, code 00796 *Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)*, the PIPPA work intensity was equal to critical care intensity of 0.090.

Post-Anesthesia Time
The post-anesthesia time is referenced to codes the E/M service levels assigned to the original 19 codes.

- Codes with a base unit of 3 are referenced to code 99211 (work RVU=0.17),
- Codes with base units 4-16 are referenced to 99231 (work RVU=0.76) and
- Codes with base units 17-30 are referenced to a blend of 99232/99231 (work RVU=1.08).

The ASA raised concern with the assignment of code 99211 to codes assigned a base unit of 3. The ASA contends that the work in the post anesthesia time is more than that of 99211, which does not require the presence of a physician. While the workgroup agreed that the work performed by the anesthesiologist is at a higher level than that of 99211, to be consistent with the original work of the second Five-Year Review Workgroup, they chose to keep the level assigned to 3 base unit codes at 99211. The Workgroup advised the ASA could request the issue be re-evaluated at a later date. The ASA did agree with the overall assignment of values of Post-Anesthesia Time.

Lastly, ASA revised the model to incorporate the building block changes, which the workgroup reviewed and approved. The net undervaluation of anesthesia work was 32% compared to the regression model estimation of 34%. Based on the extensive review of all the building block components and validation of PIPPA work by surgeons on the Workgroup familiar with anesthesia services associated with their specialty, the Workgroup reached unanimous agreement that the revised model predicts anesthesia undervaluation. **The RUC will recommend to CMS that Anesthesia work is undervalued by 32%.**

The RUC also identified three anesthesia services that may be misvalued based on this analysis and recommend that CMS allow review of the base units for at an upcoming RUC meeting:

00142 ***Anesthesia for procedures on eye; lens surgery****
00210 ***Anesthesia for intracranial procedures; not otherwise specified****
00562 ***Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator****
**Assumed to be overvalued, base unit too high or incorrect quintile assumption in the second Five-Year Review valuation.*

Chairman's Report
RUC

April 26-29, 2007

Chicago, IL

AMA
TOGETHER WE ARE STRONGER




RUC Meeting

- Financial Disclosure Forms-must be on file prior to presentation
- Attestations of Survey data should be signed with or after the submission of the SOR. AMA had received statements from Advisors prior to submission of any recommendations
- Before the presentation of a new code, the Chairman will ask presenters to declare any conflicts
- Before a presentation, any RUC member with a conflict will state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or debate for their society




RUC Meeting

- **Cell phones!!!**




Procedural Issues

- For new codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PERC recommendations or PEAC standards. If the society has not accepted PERC recommendations or PEAC conventions, the tab will be immediately referred to a Facilitation Committee before any WRVU discussion.




Procedural Issues

- October 2006 – The RUC reaffirmed that RUC advisors and presenters verbally disclose financial conflicts prior to presenting relative value recommendations
- The RUC also recommended that the RUC Chair ask RUC advisors and presenters to verbally disclose any travel expenses for the RUC meeting paid by an entity other than the specialty society




Summary of Recommendation Form

- Please note the new summary of recommendations forms
- The RUC should provide any feedback if sections of the summary are incorrect (modifier – 51, PLI crosswalk, etc.)
- All specialty societies presenting the survey data are required to sign the attestation statement at the bottom of the summary of recommendation form




Conflict of Interest

- If you have not submitted your signed conflict of interest statement, please hand in to Susan Clark before the end of this meeting.




Response to Articles

- "The Primary Care-Specialty Income Gap: Why it Matters" in the February 20, 2007 edition of the *Annals of Internal Medicine* Volume 146 Issue 4, Pages 301-306
- Rapid response is on-line, full print letter to appear soon
- www.annals.org




CMS Representatives

- Edith Hambrick, MD
- James Hart
- Carolyn Mullen
- Ken Simon, MD
- Pam West, DPT




Medicare Contractor Medical Directors

- Charles Haley, MD




MedPAC Staff

- Carol Carter




Practice Expense Review Committee in Attendance

- Katherine Bradley, PhD, RN
- Joel Brill, MD
- Manuel D. Cerqueria, MD
- Neal Cohen, MD
- Thomas Felger, MD
- Gregory Kwasny, MD
- Peter McCreight, MD
- Bill Moran, MD
- Tye Ouzounian, MD
- James Regan, MD




Facilitation Committee #1

Immune Globulin, Tab H
Thursday, April 26, 8:00-9:00am

Add-On Maze Procedures, Tab 23
Saturday, April 28, 7:00 – 8:00am

Gregory Kwasny, MD, Chairman
Ronald Burd, MD
Mary Foto, OTR
Meghan Gerety, MD
Bernard Pfeifer, MD
David Regan, MD
Arthur Traugott, MD
Robert Vogelzang, MD




Facilitation Committee #2

Percutaneous Renal Tumor Cryotherapy, Tab A
Thursday, April 26, 9-10am

Cardiac MRI, Tab 4
Thursday, April 26, 10-11am

- James Blankenship, MD, Chairman
- Bibb Allen, MD
- Michael Bishop, MD
- Barbara Levy, MD
- Charles Mick, MD
- Alan Plummer, MD
- J. Baldwin Smith, MD
- Lloyd Smith, DPM
- Bill Moran, MD




Facilitation Committee #3

Alcohol/Drug Screening & Brief Intervention, Tab M

Conference Call – Tuesday, April 17, 7:00-8:00pm (CT)

- Susan Spires, MD, Chairwoman
- Neal H. Cohen, MD
- John Derr, MD
- Thomas Felger, MD
- Anthony Hamm, DC
- Charles Koopmann, MD
- James Maloney, MD
- William J. Mangold, Jr, MD
- Gregory Przybylski, MD




Facilitation Committee #4

External Fixation, Tab 6

Friday, April 27, Noon-1:00pm

- James Regan, MD, Chairman
- Katherine Bradley, PhD, RN
- Norman Cohen, MD
- John Gage, MD
- David Hitzeman, DO
- J. Leonard Lichtenfeld, MD
- Daniel Mark Siegel, MD
- Peter Smith, MD
- Richard Tuck, MD




RUC Observers

- John Allen – American Gastroenterological Association
- Chip Amoe – American Society of Anesthesiologists
- Allan Anderson – American Psychiatric Association
- Margie Andreae – American Academy of Pediatrics
- William Beach – American Academy of Orthopaedic Surgeons
- David Beyer, MD – American Society for Therapeutic Radiology and Oncology
- Anne Marie Bicha – American Gastroenterological Association
- Richard Brown, MD – American Psychiatric Association
- Melissa Cacia – American Association of Clinical Endocrinologists
- Scott Collins, MD – American Academy of Dermatology
- Peter Conti – Society of Nuclear Medicine




RUC Observers

- William Creevy, MD – Orthopaedic Trauma Association
- Maureen Dennis – American College of Radiology
- Alan Desmond – American Academy of Audiology
- Jane Dillion, MD – American Academy of Otolaryngology – Head and Neck Surgeons
- Yolanda Doss – American Osteopathic Association
- Meghann Dugan – American Society for Therapeutic Radiology and Oncology
- Robert Fine – American Academy of Orthopaedic Surgeons
- Richard Fogel – American College of Cardiology
- Neal Freeman – American Academy of Ophthalmology
- Edward Fry, MD – American College of Cardiology
- Brian Galinat – American Urological Association
- Emily Gardner – Society of Nuclear Medicine




RUC Observers

- Larry Gentilello, MD – American Psychiatric Association
- Richard Gilbert, MD – American Urological Association
- Lawrence Green – American Academy of Dermatology
- Janis Gregory – American Urological Association
- David Han – Society for Vascular Surgery
- William Hanke, MD – American Academy of Dermatology
- Robert Harris – American College of Obstetricians and Gynecologists
- Doug Huynh – Society of Interventional Radiology
- Allan E. Inglis, Jr, MD – American Academy of Orthopaedic Surgeons
- Robert Jasak – American Academy of Orthopaedic Surgeons
- Kirk Kanter – Society of Thoracic Surgeons
- Charles Kirkpatrick – American Academy of Allergy, Asthma & Immunology




RUC Observers

- Debra Lansey – American Academy of Otolaryngology – Head and Neck Surgeons
- James Lingeman – American Urological Association
- Jennifer Markkanen – American Academy of Sleep Medicine
- Karra Markley, MD – College of American Pathologists
- Ted Martin – American College of Cardiology
- Edward Martin – American College of Cardiology
- Amy Melnick - American College of Cardiology
- Jennifer Mercurio – American Geriatrics Society
- Erika Miller – American College of Physicians
- Lisa Miller Jones, MS – American Academy of Audiology
- Keith Naunheim – Society of Thoracic Surgeons
- Gerald Niedzwiecki, MD – Society of Interventional Radiology
- Diane Pedulla – American Psychological Association




RUC Observers

- Wayne Powell – American College of Cardiology
- Jeffrey Rich – Society of Thoracic Surgeons
- Paul Rudolph, MD – American Geratrics Society
- Debra Sedlak – Joint Council of Allergy Asthma and Immunology
- Bruce Shingleton, MD – American Urological Association
- Matthew Sideman – Society for Vascular Surgery
- Craig Sobolewski – American College of Obstetricians and Gynecologists
- James Startzell – American Association of Oral and Maxillofacial Surgeons
- Kay Sykes - American College of Surgeons
- Lynne Szott, RN – Joint Council of Allergy Asthma and Immunology
- Kate Thomas – American Academy of Audiology
- Carl Tommaso, MD – American College of Cardiology
- Sean Tutton – Society of Interventional Radiology




RUC Observers

- Chris Welch – American Association of Clinical Endocrinologists
- Holly Whelan – The Endocrine Society
- Bruce Wilkoff, MD – American College of Cardiology
- Joanne Willer – American Academy of Orthopaedic Surgeons
- Kaivn William – American Osteopathic Association
- Kadyn Williams – American Audiology Association




Au Revoir

- Mary Foto, OTR – HCPAC Co-Chair
- Charles Mick, MD – North American Spine Society
- David Regan, MD - American Society of Clinical Oncology

Recommended Time Recommendations*

Physician Time Allocations - Final																		
									40	20	38	16	23	40	55			
CPT Code	**Submitted by**	**Long Descriptor**	**Global**	**Pre Eval**	**Pre Positioning**	**Pre Scrub**	**intra**	**Immed Post**	**99232**	**99231**	**99238**	**99212**	**99213**	**99214**	**99215**	**Total Existing Time**	**Recom Time**
20979	APMA	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	000		Pending Specialty Survey Option											0	0
21116	AAOMS	Injection procedure for temporomandibular joint arthrography	000	10			25									115	35
28636	APMA	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	000	20	5	10	27	15								77	77
28666	APMA	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation	000	20	5	10	37	15								87	87
29850	AAOS	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	90	23	15	10	60	17			0.5	3				192	192
29851	AAOS	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)	90	35	15	10	90	20			0.5	1	3			287	274
29855	AAOS	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation (includes arthroscopy)	90	30	15	10	95	8			0.5	2	2			255	255
29856	AAOS	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)	90	30	15	10	135	8			1	2	2			314	314
35459	SVS	Open tib peroneal angioplasty	0	30	15	20	118	35								218	218
35460	SVS	open venous angioplasty	0	30	15	20	60	35								160	160
35480	SVS	Open renal visceral atherectomy	0	30	15	20	150	35								250	250
35481	SVS	Open aortic atherectomy	0	30	15	20	103	35								203	203
35482	SVS	Open iliac atherectomy	0	30	15	20	80	35								180	180
35483	SVS	Open fem-pop atherectomy	0	30	15	20	108	35								208	208
35484	SVS	Open brachiocephalic atherectomy	0	30	15	20	150	35								250	250
35485	SVS	Open tib-peroneal atherectomy	0	30	15	20	131	35								231	231

These Time Allocations will be flagged within the RUC database with "DO NOT USE TO VALIDATE FOR PHYSICIAN WORK"

Recommended Time Recommendations*

Physician Time Allocations - Final																		
									40	20	38	16	23	40	55			
CPT Code	**Submitted by**	**Long Descriptor**	**Global**	**Pre Eval**	**Pre Positioning**	**Pre Scrub**	**intra**	**Immed Post**	**99232**	**99231**	**99238**	**99212**	**99213**	**99214**	**99215**	**Total Existing Time**	**Recom Time**
37207	SVS	Open stent placement intial vessel	0	30	15	20	108	35								208	208
47564	ACS	Laparoscopy, surgical; cholecystectomy with exploration of common duct	90	30			112	45	1	1	1	3				333	333
50727	AUA	Revision of urinary-cutaneous anastomosis (any type urostomy);	90	7	5	5	75	20		1	1	2	1			225	225
50728	AUA	Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia	90	7	5	5	106	20		1	1	1	3			286	286
50782	AUA	Ureteroneocystostomy; anastomosis of duplicated ureter to bladder	90	7	5	5	200	20		2	1		3			384	384
50783	AUA	Ureteroneocystostomy; with extensive ureteral tailoring	90	7	5	5	227	20		2	1	1	3			427	427
51701	AUA	Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)	0	5	5	3	9	3								25	25
52355	AUA	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	0	7	5	13	25	23								175	73
52450	AUA	Transurethral incision of prostate	90	15	5	5	81	15			0.5		3			209	209
54401	AUA	Insertion of penile prosthesis; inflatable (self-contained)	90	15	5	5	103	15			0.5		2	1		248	248
61050	NASS	Cisternal or lateral cervical (C1-C2) puncture; without injection (separate procedure)	0	20			20	8								48	48
61760	AANS, CNS	Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring	0	128			200	30		2	1		3			505	505
64505	NASS	Injection, anesthetic agent; sphenopalatine ganglion	000	8			16	8								32	32
64530	ASA	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring	000	10			30	9								49	49
66986	AAO	Exchange of Intraocular lens	000	45	5	10	90	110								260	260
90997	RPA	Hemoperfusion (eg, with activated charcoal or resin)	000	10			25	5								45	40

These Time Allocations will be flagged within the RUC database with "DO NOT USE TO VALIDATE FOR PHYSICIAN WORK"

Recommended Time Recommendations*

Physician Time Allocations - Final																	
									40	20	38	16	23	40	55		
CPT Code	**Submitted by**	**Long Descriptor**	**Global**	**Pre Eval**	**Pre Positioning**	**Pre Scrub**	**intra**	**Immed Post**	**99232**	**99231**	**99238**	**99212**	**99213**	**99214**	**99215**	**Total Existing Time**	**Recom Time**
91100	ACOG	Intestinal bleeding tube, passage, positioning and monitoring	000	4			20	5								29	29
91105	ACEP	Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons)	000	2	2	1	8	3								16	16
92995	ACC	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel	000	60			155	60								275	275
93631	STS, ACC	Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction	000	25			127	10								162	162

These Time Allocations will be flagged within the RUC database with "DO NOT USE TO VALIDATE FOR PHYSICIAN WORK"

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report
Thursday, April 19, 2007

Dr. Bradley, PhD (Chair), Joel Brill, MD, Thomas Felger, MD, Bill Moran, MD, and Bob Zwolak, MD met via conference call to review and discuss physician time allocations submitted by specialties for practice expense purposes.

Subcommittee members reviewed the time allocations for usual time allocations and where the established guidelines were not followed. Committee members accepted all of the physician time allocations as submitted with two exceptions:

CPT code 20979 *Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)* (Work RVU = 0.62). AMA staff noted that the service did not have any physician time recorded from RUC survey or other sources, and that when the code was reviewed at the RUC for CPT cycle 2000, no specialty society indicated an interest in surveying the new code for either work or practice expense. The RUC database time is zero physician time for the code. In the absence of formal survey data the RUC was unable to make a final recommendation regarding physician work at that time. The RUC however did supply CMS with information regarding a similar procedure with Harvard physician time components CPT code 20974 *Electrical stimulation to aid bone healing; noninvasive (nonoperative)* (Work RVU = 0.62) for making their decision on physician work.

The American Podiatric Medicine Association (APMA) now recommends a crosswalk of the physician time components of code 20974 to 20979. Subcommittee members understood that cross-walking physician time components to increase recorded time is not within the established guidelines. The specialty is required to perform a full RUC survey and present the results to this committee if they recommend an increase in time. The Subcommittee recommends: **The physician time for code 20979 should remain at zero, with the option for the specialty society to conduct a physician time survey to be validated by this committee.**

CPT code 47564 *Laparoscopy, surgical; cholecystectomy with exploration of common duct* (Work RVU = 14.21). The Subcommittee reviewed the physician time allocations recommended by the American College of Surgeons (ACS) which was based on survey data presented to the RUC in 1993. These same survey results were presented to the RUC in 1993 and were not approved by the RUC as there were only 11 respondents. Subcommittee members recognized the low response rate from the survey and that the recommended intra-service time was inconsistent with the survey results from 1993. Discussion focused on the invalid 1993 survey results, the perception of a high intra-service physician time by some members, and the established guidelines for physician time allocations. **The subcommittee recommends the intra-service time recommended by ACS for 47564 to be 112 minutes from 145 minutes so that the total time recommended equated with the current total physician time in the RUC database (333 minutes).**

Lastly, there were two codes where AMA staff received different time allocations from specialties. Codes 61050 and 64505. Specialties came to consensus by agreeing with recommendations from the North American Spine Society. The Subcommittee also recommends these time allocations.

All physician time recommendations are located in Tab X for RUC review and approval, and will be modified as discussed above. This concludes this physician time allocation exercise for this Subcommittee.

RUC approved April 29, 2007

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
March 27, 2007 – Via Conference Call

Members Present: Norman A. Cohen, MD, (Chair), Charles Koopmann, Jr., MD, David Hitzeman, DO, Daniel Mark Siegel, MD, J. Baldwin Smith, MD,

I. Specialty Society Request – Renal Physicians Association – Review of Survey for End Stage Renal Disease (ESRD) Codes

AMA Staff received a request from CMS regarding the ESRD codes. CMS states, "As you know, in the physician fee schedule final rule for 2007, we did not implement the RUC recommendation to apply the increases in the e/m codes to the G-codes for ESRD physician services. As we stated in the rule, we did not have the information to know what assumptions to make regarding the level of e/m visits to use as part of the building blocks for each of these services. At that time, we also indicated that we would like for the renal physicians to take these G-codes to the RUC, so that we could receive more specific recommendations on the appropriate RVUs for these services. We, therefore, request formally that the RUC review any of the ESRD G-codes that the renal physicians wish to present."

RPA stated that they would like the RUC's Research Subcommittee to review their proposed survey methodology as they plan to survey this issue for the October 2007 RUC meeting. The Research Subcommittee reviewed RPA's proposal. **The Research Subcommittee recommends that the specialty review the existing language associated with the temporary ESRD G-codes and submit a coding proposal to the CPT Editorial Panel defining these services and typical patients.** Further, the Research Subcommittee offered to review vignettes, proposed educational materials and proposed survey instruments at its September 2007 RUC Meeting.