AMA/Specialty RVS Update Committee
April 27-30, 2000

The Knickerbocker Hotel
Chicago, Illinois

I. **Call to Order:**

Doctor James G. Hoehn called the meeting to order on Thursday, April 27, 2000 at 2:23 p.m. The following RUC members were in attendance:

James G. Hoehn, MD, Chair
Joel Bradley, MD
James Blankenship, MD
Lee Eisenberg, MD
Robert Florin, MD
John Gage, MD
William Gee, MD
Alexander Hannenberg, MD
W. Benson Harer, MD
James Hayes, MD
Richard J. Haynes, MD
David Hitzeman, MD
Charles Koopmann Jr., MD
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
James Maloney, MD*
David L. Massanari, MD
John Mayer, MD
David L. McCaffree, MD
James Moorefield, MD
Bill Moran, MD
Alan L. Plummer, MD
Greg Przyblski, MD
David Regan, MD
William Rich, MD
Peter Sawchuk, MD*
Ronald Shellow, MD*
Paul Schnur, MD
Bruce Sigsbee, MD
Sheldon Taubman, MD
Trexer Topping, MD*
Laura Tosi, MD*
Richard Whitten, MD*
Don E. Williamson, OD
Robert Zwolak, MD

* Alternate RUC Member

II. **Chair's Report:**

Doctor Hoehn welcomed RUC members and announced the following changes and re-appointments to the RUC composition:

- Doctor Bill Moran as new chair of the Practice Expense Advisory Committee (PEAC).
- Doctor Hoehn announced the retirement of Doctor W. Benson Harer. On behalf of the RUC, Doctor Hoehn presented Doctor Harer with a token of appreciation and expressed the RUC's gratitude for the many years of personal commitment to the RUC process.
- Doctor Hoehn informed the RUC that Doctor William Winters sent a note that indicated his appreciation for the opportunity to participate in the RUC process. Doctor Winter's term concluded with the February 2000 RUC meeting.

Doctor Hoehn announced new appointments and re-appointments to the RUC which are as follows:

1) Doctor Joel Bradley
2) Doctor William Gee
3) Doctor Alexander Hannenberg
4) Doctor Richard J Haynes
5) Doctor Charles F. Koopmann, Jr.
6) Doctor Barbara S. Levy
7) Doctor David Massanari
8) Doctor John E. Mayer, Jr.
9) Doctor David L. McCaffree
10) Doctor William Rich
11) Doctor Bruce Sigsbee

Doctor Hoehn informed RUC members about the American Medical Association's realignment and announced that the RUC staff will now report to the Advocacy Group at the AMA.

Doctor Hoehn introduced Jim Rodgers PhD, Vice President of Health Policy. Dr. Rodgers explained that the AMA's organizational changes should not directly affect the RUC's operations. Dr. Rodgers stated that the AMA continues to view the RUC as a successful cooperative arrangement and will continue to provide financial and staff support to the process.

Dr. Rodgers informed RUC members about the discontinuation of the SMS survey in its current format. He explained that it has become increasingly difficult to administer the survey as physician responses are difficult to obtain and the costs have increased tremendously. He announced that the AMA has formed an internal workgroup to consider new options in collecting and/or obtaining this data. RUC members expressed serious concern regarding the discontinuation of the SMS survey. RUC members indicated that the survey was the only data collected that has been accepted by HCFA and voiced concern regarding the need to collect future data to refine practice expense relative values. Dr. Rodgers agreed to provide periodic updates on the AMA's activities regarding future data collection.

Doctor Hoehn announced that he had approved the American Burn Association and the American Society of Transplant Surgeons request to appoint a member to the RUC's Advisory Committee.

Doctor Hoehn requested that as there is a great amount of work to accomplish, presenters should confine their comments to five minutes. Doctor Hoehn explained that during the discussion phase, he will call upon assigned RUC members to help facilitate the presentation and that open discussion will be limited to two minutes per individual.

Doctor Hoehn announced the Facilitation Committees:

Facilitation Committee 1	Facilitation Committee 2
David Hitzeman, DO (Chair)	W. Benson Harer, MD (Chair)
Robert Florin, MD	John Gage, MD
Alexander Hannenberg, MD	Charles Koopmann, MD
John E. Mayer, MD	David McCaffree, MD
William Rich, MD	David Regan, MD
Bruce Sigsbee, MD	Sheldon Taubman, MD
Sherry Barron-Seabrook, MD (Advisor)	Sandra Reed, MD (Advisor)
James Georgoulakis, PhD (HCPAC)	Marc Lenet, DPM (HCPAC)

Facilitation Committee 3	Facilitation Committee 4
Peter Sawchuck, MD (Chair)	Joel Bradley, MD (Chair)
James Regan, MD	Richard Haynes, MD
J. Leonard Lichtenfeld, MD	David Massanari, MD
James Moorefield, MD	Alan Plummer, MD
Ronald Shellow, MD	Paul Schnur, MD
Robert Zwolak, MD	Richard Whitten, MD
Karl Becker, MD (Advisor)	John Derr, MD (Advisor)
Samuel Brown, PT (HCPAC)	Nelda Spyres, LCSW (HCPAC)

III. **Director's Report**

Sherry Smith presented the Director's Report to the RUC members. Sherry Smith informed RUC members that an updated meeting schedule was placed in Tab 2 of the RUC Agenda Book.

Upcoming RUC meetings include:

August 24-27, 2000	Swissotel, Chicago, Illinois
October 5-8, 2000	Westin O'Hare, Chicago, Illinois
February 1-4, 2001	The Pointe Hilton at Tapatio Cliffs, Phoenix, Arizona

IV. Approval of Minutes for the February RUC meeting

The RUC approved the February 2000 minutes without modification.

V. **CPT Update**

Doctor Lee Eisenberg, CPT representative to the RUC, presented the CPT update to the RUC members. Doctor Eisenberg announced that CPT is beginning the 2002 cycle with the May 2000 Panel meeting. Doctor Eisenberg then provided a brief update on CPT-5 including implementation of the new tracking codes to describe new technology and performance measurements. Doctor Eisenberg also announced that CPT will place new 2001 immunization codes on the website to facilitate the usage and reporting of these codes in advance of their publication of the CPT 2001 book.

VI. **Health Care Financing Administration (HCFA) Update**

Doctors Paul Rudolf and Tom Marciniak presented the HCFA update to the RUC members on the following issues:

- Doctor Rudolf informed RUC members that HCFA will present to the CPT Editorial Panel proposed revisions to the Critical Care guidelines at the May 2000 Panel meeting.
- Doctor Rudolf indicated that the Carrier Medical Directors (CMD) will be attending the Five-Year Workgroup meetings and Doctor Rudolf hopes this will facilitate the CMD's understanding of these codes and assist in HCFA's review of the RUC recommendations.
- Regarding the Five-year review, Doctor Rudolf informed RUC members that HCFA is still continuing to research physician time. HCFA is currently completing two studies. The first is a review of DJ Sullivan operating room time to make direct comparisons to intra-time for major surgical services. The second pilot study has reviewed inpatient and outpatient records for general surgical services to validate the number and level of visits currently captured in the RUC and Harvard data. Doctor Rudolf will present the results of this study at a future RUC meeting.
- Doctor Tom Marciniak commented on the PEAC meeting and that Doctor William Moran, the new PEAC chair ran a successful meeting. Doctor Marciniak informed RUC members that the Final Rule on Outpatient Prospective Payment System was published on April 7, 2000 and explained that the deadline for public comments is June.
- Regarding CPT issues, Doctor Marciniak stated that ocular photodynamic therapy had recently been identified as an issue that needs to be addressed. The descriptor of this new technology was added to CPT code 67220 in year 2000 and the CPT Editorial Panel indicated that this was an editorial change; and therefore would not go through the RUC process. Doctor Marciniak explained that the work, however, is much different and the action was <u>not</u> editorial. In fact, he estimated that overpayment for this service could potentially reduce overall physician payment via the Sustained Growth Rate (SGR), by a total of 1%. In response, Doctor Eisenberg explained that the CPT Editorial Panel made the decision based upon the advice of the individuals proposing the coding change, who deemed this issue to be an editorial revision. Grace Kotowicz further explained that the proposal contained a request for a new code; however, after Advisor review it was determined that the procedure should be included in the existing CPT code and that a new code should not be created. AMA staff suggested that the RUC might wish to review a listing of proposed "editorial" changes in the future to provide additional advice regarding whether a coding change is indeed editorial.

VII. **Washington Update**

Sharon Mcllrath from the AMA's Washington office reviewed a number of legislative and regulatory initiatives.

On the Legislative side:

- The conference on Patient Bills of Rights is still convening. The key remaining issues still to be resolved are the scope of the Bill of Rights, the resistance of the Senate regarding accountability and reliability.
- The House Judiciary Committee approved the Campbell Bill in March, which will permit physicians to work together in negotiations with managed care plans. Included is an amendment that would cause this to sunset after three years and calls for an FTC study to help determine if it should continue.
- The House passed a Pain Relief Act of 1999 bill last fall.
- Medicare reform is still being addressed.

On the Regulatory Side:

- Congress told HCFA to develop a new SGR for calendar year 2000. This would permit spending to increase by 5.8% compared to the 2.1% in the earlier calculation. HCFA has estimated that this will result in a 1.8% update next year.
- A final rule on the Outpatient Prospective Payment System was published earlier in April 2000 and will be open for comment on several new features that are required under the Balanced Budget Refinement Act (BBRA). This system creates groups of services and then reimburses the same amount for every service in that group. Implementation is set for July 1.
- HCFA intends to expand the process in its campaign regarding Fraud and Abuse and enrollment form. As a result, all physicians will have to fill out a new enrollment form. The information on this form would have to be revalidated every 3 years.
- Health and Human Services Office of Civil Rights issued a proposed rule that would require physicians' offices to provide interpreters for non-English speaking patients.

VIII. Relative Value Recommendations

Chemodenervation of Muscles of the Trunk and the Limbs (TAB 5)
Presenters: James Anthony, MD and Richard Harvey, MD
Reviewed by Facilitation Committee 1

New CPT code 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* was created to describe injection of botulinum toxin into the limb and trunk muscle(s) for treatment of dystonia, spasticity, cerebral palsy, multiple sclerosis and muscle spasms. Botox is a neurotoxin that irreversibly blocks acetocholine, which results in partial paralysis of the muscles. Typically, for vocal dystonia the physician targets two muscles for injection in which EMG localization is used to identify the muscles. The physician typically targets four to eight muscles for injection in a limb. CPT currently contains codes for chemodenervation for muscles of the face and neck; however, CPT does not contain a code that accurately describes chemodenervation of the trunk and/or limb muscles.

The RUC did not accept the initial specialty society work value recommendation for new code 64614. Facilitation Committee One reviewed this issue and presented the following recommendation to the RUC.

The intensity of work for new code 64614 is greater than the reference service code 64613 *Destruction by neurolytic agent (chemodenervation of muscle endplate); cervical spinal muscles (eg, for spasmodic torticollis)* (work RVU = 1.96), as the muscles to be injected are not easily determinable and there are a greater number of injections performed in the trunk and/or limb muscles. Also, the dosage of botox given is substantially higher in new code 64614 than compared to the reference service code. The RUC noted that this procedure is more difficult and involves more work, as the typical patient is either a stroke or cerebral palsy patient. Additionally, this procedure involves injections into 4-8 muscles whereas the reference service code typically involves injections into less than 4 muscles. The RUC also compared code 64614 to 67345 *Chemodenervation of extraocular muscle* (work RVU = 2.96). The RUC agreed that 2.20 is appropriate as it reflects increased work over codes 64612 and 64613.

The RUC recommends a work relative value of 2.20 for CPT code 64614.

CPT codes 64612 *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)* and 64613 *Chemodenervation of muscle(s); cervical spinal muscle(s) (eg, for spasmodic torticollis)* were revised; however, the RUC does not recommend a change in the work relative values.

Practice Expense Recommendations
The RUC agreed that the list of practice expenses accurately reflected the resources required to perform the procedure in the non-facility setting. There are no direct practice expense inputs when performed in a facility setting.

<u>Cryosurgical Ablation of the Prostate (TAB 6)</u>
Presenter: **James B. Regan, MD**
Reviewed By Facilitation Committee 2

New CPT code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)* describes cryosurgical ablation of the prostate due to prostate cancer. Cryosurgical ablation of the prostate consists of freezing a cancerous prostate causing cell destruction and death. New code 55873 includes placement of a suprapubic tube, which is included in the work of 55873 and not separately reported. Currently, this procedure is reported using the unlisted code 55899 *Unlisted procedure, male genital system*, as CPT does not contain a code that accurately describes this service.

The RUC did not accept the initial specialty society work value recommendation for new code 55873. A Facilitation Committee reviewed this issue and presented the following recommendation to the RUC.

The time and intensity and complexity measures for new code 55873 were compared to the original reference service code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work RVU = 28.55).

However, the RUC agreed the work of new code 55873 was more comparable to the work and time described by code 55801 *Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)* (work RVU = 17.80) with the ultrasonic guidance component included in code 55873. The total physician time of 395 minutes for code 55873 is comparable to the total physician for 55801 of 461 minutes.

The RUC recommends a work relative value of 17.80 for code 55873.

Practice Expense Recommendations
The RUC recommends that the pre-service clinical staff time be reduced from 89 minutes to 45 minutes (for RN/LPN) to be consistent with other codes in the family. The RUC recommends approval of all other practice expense inputs for this service as presented. This service is performed in a facility setting.

76967
The RUC recommended that the CPT Editorial Panel reconsider its action to create a separate code for ultrasonic guidance for interstitial cryosurgical probe placement, as this service is an inherent component of the cryosurgical ablation of the prostate, code 55873.

The CPT Editorial Panel subsequently rescinded its earlier action to create this code and bundled this service into the primary procedure.

Reversal of Sling Operation for Stress Incontinence (TAB 7)
Presenters: James B. Regan, MD, Sandra Reed, MD
Reviewed by Facilitation Committee 2

New CPT code 57287 *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)* describes the removal or revision of a sling due to infection, graft erosion or persistent urinary retention. Currently, CPT does not contain an existing code that accurately describes this service; therefore, this service was reported using the unlisted code 58999 *Unlisted procedure, female genital system (nonobstetrical)*.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

New code 57287 was originally compared to the reference service code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 13.02); however the RUC determined the work to be more comparable to code 51840 *Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz, Burch); simple* (work RVU = 10.71) and accordingly recommends a work relative value of 10.71. The RUC noted that the Harvard intra-service time for code 51840 is 74 minutes, which the RUC agreed to be more comparable to the 70 minutes of intra-service time for new code 57287.

The RUC recommends a work relative value of 10.71 for code 57287.

Practice Expense Recommendation
The practice expense inputs for 57287 were crosswalked from existing inputs for CPT code 51845 *Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)*. The RUC approved the practice expense inputs for 57287 with the following recommended changes:

- Syringe with water be modified to be supply code 91407 Syringe, 10cc – 12cc.
- The staff type was changed from RN only to RN/LPN
- Staple removal kit removed from medical supplies
- Ultrasound removed from overhead medical equipment

This service is provided in a facility setting.

Endometrial Ablation (TAB 8)
Presenters: George Hill, MD and Sandra Reed, MD

New CPT code 58353 *Endometrial ablation, thermal, without hysteroscopic guidance* was created to describe the use of thermal energy to ablate uterine tissue. Currently, this procedure is reported using code 58563 *Hysteroscopy, surgical; with endometrial ablation (any method)* (work RVU = 6.17) with the modifier –52 (Reduced Services) appended. However, the existing code 58563 describes the procedure performed via a hysteroscope whereas the service described by new code 58353 is performed without using a hysteroscope.

The RUC agreed the physician work for new code 58353 (work RVU = 3.56) was not comparable to the original reference service code 58563 *Hysteroscopy, surgical; with endometrial ablation (any method)* (work RVU = 6.17). The RUC determined that it would be appropriate to subtract the work of a diagnostic hysteroscopy, code 58555 *Hysteroscopy, diagnostic (separate procedure)* (work RVU = 3.33) from the hysteroscopic endometrial ablation code 58563 (work RVU = 6.17), to yield a work relative value of 2.84. However, this value did not reflect the work inherent in dilating the cervix, sounding the uterus and inserting the balloon device. The RUC determined this work to be comparable to that of inserting an intrauterine device, code 58300 *Insertion of intrauterine device (IUD)* (work RVU = 1.01). The RUC added in the work of 58300 (work RVU = 1.01) to 2.84 to obtain a total work relative value of 3.85. This was similar to the survey 25th percentile work RVU = 3.56, which was also the recommended specialty society work value; therefore, the RUC agreed that 3.56 was an acceptable work value.

The RUC recommends a work relative value of 3.56 for code 58353.

Practice Expense Recommendations
The RUC approved the direct practice expense inputs. These inputs were originally developed by the specialty's consensus Panel and standard supply packages were applied to this code. The RUC removed the autoclave from the overhead equipment category. This service is performed in a facility setting.

Incision and Drainage of Vaginal Hematoma (TAB 9)
Presenters: George Hill, MD and Sandra Reed, MD

New CPT code *57022 Incision and drainage of vaginal hematoma; post-obstetrical* describes the procedure of incising and draining a vaginal hematoma. Vaginal hematomas may occur as a complication of delivery, vaginal surgery and as a result of accidents. Typically, this procedure is performed on obstetrical patients in the global

obstetrical period; however, this procedure requires a return trip to the operating room and therefore, is not considered to be included in the global obstetrical package. This service is also typically performed on an urgent basis. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted codes 58999 *Unlisted procedure, female genital system (nonobstetrical)* or 59899 *Unlisted procedure, maternity care and delivery* were reported.

The RUC compared new code 57022 to the reference service code *56405 Incision and drainage of vulva or perineal abscess* (work RVU = 1.43). When evaluating the pre and intra-service times and intensity and complexity measures for new code 57022, these measures were greater than the reference service code 56405 due to the technical difficulty of the procedure and the need to stabilize the patient and arrange for operating room time, as this procedure is often performed on an emergent basis. Based upon the greater intensity and complexity measures for new code 57022, the RUC agreed that this procedure was more comparable to the reference service code 59160 Curettage, postpartum, which has a work RVU of 2.71. The RUC agreed that the recommended work value of 2.56, which was also the survey median work relative value was appropriate.

The RUC recommends a work relative value of 2.56 for code 57022.

The RUC noted that this recommendation is appropriate for obstetrical patients; however, incision and drainage of vaginal hematomas for sexual abuse cases represents more physician work. The RUC recommends that the specialty society pursue a new code to report this service. A new code was subsequently added by the CPT Editorial Panel. The RUC did not have an opportunity to review this service. A recommendation will be reviewed by the RUC in February 2001, and the RUC will forward the recommendation to HCFA at this time.

Practice Expense Recommendation
The direct inputs for this code were developed by a specialty consensus panel. The specialty's standard supply packages were approved by the RUC with the deletion of the autoclave from the overhead equipment category. This service is performed in a facility setting.

Hormone Pellet Implantation (TAB 10)
Presenters: George Hill, MD and Sandra Reed, MD

For CPT 2000, a new CPT code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* was added to

describe the subcutaneous placement of hormone pellets. Hormone pellets are typically inserted every three-six months and do not have to be removed. Currently, CPT does not contain an existing code that accurately describes this service; therefore the unlisted code 17999 *Unlisted procedure, skin, mucous membrane and subcutaneous tissue* is reported.

When the RUC compared new code 11980 to the reference service code 11975 *Insertion, implantable contraceptive capsules* (work RVU = 1.48), the RUC noted that the work for new code 11980 was identical to the work described by the reference service code 11975 (work RVU = 1.48). As an interim value, HCFA previously assigned a work relative value of 1.48, which is identical to the reference service code (11975). The RUC agreed the work was comparable to the reference service code and agreed the recommended survey work value of 1.48 was appropriate.

The RUC recommends a work relative value of 1.48 for code 11980.

Practice Expense Recommendations
The direct inputs were developed by a specialty consensus panel. This service may be performed in either a facility or non-facility setting. The RUC approved the use of the specialty's supply packages with the following changes:

- Deletion of the autoclave and fiberoptic exam light from the overhead equipment category for in-office services
- The Pre-clinical staff time of 2 minutes for in-office services was deleted
- The only direct input for out-of-office setting is 5 minutes of RN/LPN/MA time

Fetal Biophysical Profile (TAB 11)
Presenters: George Hill, MD, Sandra Reed, MD, James Borgstede, MD

Existing CPT code 76818 *Fetal biophysical profile* was revised to specify a fetal biophysical profile performed with non-stress testing. When performing this procedure, the physician evaluates fetal breathing movements, fetal movement, fetal tone and quantification of amniotic fluid.

The RUC compared code 76818 to the work RVU of reference service code *59025 Fetal non-stress test* (work RVU = 0.53); however this value did not include the work of the ultrasound. The RUC added the work of a limited ultrasound, code *76815 Echography, pregnant uterus, B-scan and/or real time with image documentation; limited (fetal size, heart beat, placental location, fetal position, or emergency in the delivery room)* (work RVU = 0.65) to the work RVU of code 59025 (0.53), to obtain a total relative work value of 1.18. The RUC compared this work value to the recommended work value and survey median work value of 1.05 for CPT code 76818, which the RUC agreed was an appropriate value.

The RUC recommends a work relative value of 1.05 for code 76818.

Practice Expense Recommendations
The direct inputs were developed by a specialty consensus panel. The RUC approved the supplies with minor changes and with the deletion of the tachodynanometer, autoclave, and fiberoptic exam light from the equipment categories. The RUC recommends no direct practice expense inputs in the facility setting.

76819
Work Relative Value Recommendations
New CPT code 76819 *Fetal biophysical profile; without stress or non-stress testing* was created to specify fetal biophysical profile performed without non-stress testing. When performing this procedure, the physician evaluates fetal breathing movements, fetal movement, fetal tone and quantification of amniotic fluid without performing a non-stress.

The RUC compared new code 76819 to the reference survey code 76815 (work RVU = 0.65). When evaluating the new code 76819, the time and intensity and complexity measures were greater for the new code than the reference service code (76815). Also, the physician work is more intense due to the high-risk status of the patient.

Existing code 76818 has a work RVU of 0.77 and is valued without stress or non-stress testing. Therefore, the RUC agreed that the recommended survey work RVU of 0.77 was appropriate.

The RUC recommends a work relative value of 0.77 for code 76819.

Practice Expense Recommendations
The RUC approved the recommended direct inputs with minor changes to supplies and the deletion of some overhead equipment. The laser printer was moved from the procedure specific to overhead equipment category. The RUC does not recommend any direct inputs in the facility setting.

Escharotomy (TAB 13)
Presenters: Robert W. Gillespie, MD and John W. Derr, MD

Work Relative Value Recommendation
CPT code16035 *Escharotomy; initial incision* was revised to clarify that code 16035 should be reported for a single escharotomy incision. This procedure is used in preserving pulmonary function and circulation in burn extremities. Patients requiring escharotomies generally present as emergency cases.

The RUC compared code 16035 to the reference service code 15000 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissue); first 100 sq cm or one percent of body area of infants and children* which has a work RVU of 4.00. When evaluating code 16035, the RUC noted that the urgency of medical decision-making and the risk of complications, morbidity and mortality were higher than the reference service code. As new code 16035 has greater mental effort and psychological stress, the RUC agreed that the survey

recommended work RVU of 3.75, which was also the survey median value, was appropriate. In addition, the RUC noted that the current work relative value for 16035 is 4.82. A reduction to 3.75 is appropriate, as the code will now be reported for the initial incision. If an additional incision is necessary, it will be reported with new code 16036.

The RUC recommends a work relative value of 3.75 for code 16035.

Practice Expense Recommendation

There are no direct practice expense inputs for this service, as this service is performed in a facility on an emergent basis.

16036

Work Relative Value Recommendation

CPT code 16036 *Escharotomy; each additional incision (List separately in addition to code for primary procedure)* was created to describe additional escharotomy incisions performed. Patients requiring additional escharotomy incisions are urgent cases. Currently, CPT does not contain a code that describes additional escharotomy incisions performed on a patient. CPT code 16035 *Escharotomy; initial incision* with the modifier –22 (Unusual procedural services) appended was used to describe this service. At the RUC meeting, the presenter noted that the frequency data for 16036 in the CPT Proposal was incorrect and indicated that it is estimated that 10-13% of patients require at least two incisions on a single extremity and at least four separate incisions on the chest wall.

The RUC compared new code 16036 to the reference service code 15001 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)* which has a work RVU of 1.00. The RUC noted that the complications, morbidity and mortality were greater for new code 16036 than the reference service code. There is also greater technical skill, physical and mental effort and psychological stress associated with this new procedure. Therefore, the RUC agreed that the recommended Work RVU of 1.50, which was also the survey median work value, was appropriate.

The RUC recommends a work relative value of 1.50 for code 16036.

Practice Expense Recommendation

There are no direct practice expense inputs for this service, as this service is performed in a facility on an emergent basis.

Stereotactic Breast Biopsy (TAB 14)
Presenters: James Borgstede, MD
Reviewed by Facilitation Committee 4

Work Relative Value Recommendations
New code 19102 *Biopsy of breast; percutaneous, needle core, using imaging guidance* was created to describe breast biopsy performed using imaging guidance. This procedure reflects new technology, which provides a method of breast biopsy that is minimally invasive. Per existing HCFA instructions, this service is currently being reported using CPT code 19101 *Biopsy of breast; incisional* (work RVU = 3.18).

When evaluating new code 19102 with the reference service code 19100 *Biopsy of breast; needle core (separate procedure)* (work RVU = 1.27), the RUC noted that the time and intensity and complexity measures are higher than the reference service code 19100. The RUC considered work survey results, which provided a survey median work value of 2.00. New code 19102 requires 30 minutes intra-service time compared to 10 minutes for the reference service code 19100; therefore, the RUC agreed that the recommended work relative value of 2.00 was appropriate.

The RUC recommends a work relative value of 2.00 for code 19102.

Practice Expense Recommendations
The RUC is providing recommendations for direct inputs when this service is performed in a non-facility setting only. The RUC agreed that an appropriate method for establishing clinical staff time would be to crosswalk the existing inputs from code 76942. The RUC agreed that the clinical staff activities were comparable in time (102 minutes).

Additionally, both codes 19102 and 76942 have an intra-service time of 30 minutes. The RUC further refined the clinical inputs and recommends a total clinical staff time of 100 minutes.

19103
Work Relative Value Recommendations
New code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* was created as new technology and equipment provided a new method of breast biopsy which is minimally invasive. Many of these devices are able to biopsy and remove the lesion via a minimally invasive technique.

Per existing HCFA instructions, this service is currently being reported using CPT code 19101 *Biopsy of breast; incisional* (work RVU = 3.18).

The RUC agreed that the physician work and intensity and complexity factors are greater for new code 19103 than the reference service code 19100 (work RVU = 1.27). New code 19103 has a greater complexity due to the involvement of the biopsy device, which involves complex manipulation of the device and requires additional physician time.

In addition, the RUC compared new codes 19102 and 19103 and agreed that the intensity measures in the RUC survey for 19103 reflected a more complex service than 19102. Given the additional complexity of performing the procedure, the RUC agreed that the median survey value of 2.37 was appropriate.

The RUC recommends a work relative value of 2.37 for code 19103.

Practice Expense Recommendations
The RUC is providing recommendations for direct inputs when provided in a non-facility setting only. The RUC agreed that an appropriate method for establishing clinical staff time would be to crosswalk the existing inputs from code 76942.

The RUC agreed that the clinical staff activities were comparable in time (102) minutes. Additionally, both codes 19103 and 76942 have an intra-service time of 30 minutes. The RUC further refined the clinical inputs and recommends total clinical staff time of 100 minutes.

Insertion of Breast Markers (TAB 15)
Presenters: James Borgstede, MD

CPT code 19295 *Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure)* was created to describe the placement of a metallic clip during a breast biopsy. CPT code 19295 is to be reported in addition to the code for breast biopsy.

There are no work relative value recommendations, as the RUC agreed the work for placement of the clip marker code is included in the work of the parent code.

The RUC agreed that there is minimal additional work and recommends a 0.00 work RVU for code 19295.

Practice Expense Recommendations
The RUC recommends the practice expense direct inputs for the non-facility setting. The RUC reduced the clinical staff time to two minutes to reflect an appropriate clinical staff time. Also, the RUC recommends the inclusion of marker clip as the only other practice expense input.

Mandibular Osteotomy and Genioglossus Advancement (TAB 17)
Presenter: James H. Kelly, MD, Sam McKenna, DDS, MD

New code 21199 *Osteotomy, mandible, segmental; with genioglossus advancement* was created to describe mandibular osteotomies performed with genioglossus advancement for treatment of sleep disordered breathing. Currently, CPT does not contain a code that accurately describes this procedure and this service was reported using CPT code 21198 *Osteotomy, mandible, segmental* (work RVU = 14.16) with the modifier –22 (Unusual Procedural Services).

When the RUC evaluated new code 21199, the RUC determined this new service required greater work, complexity and risk than the reference service code 21198 *Osteotomy, mandible, segmental* (work RVU = 14.16). Complex osteotomy cuts are made into the mandible to create a large window, which may weaken the bone, thereby increasing the risk for fracture during the procedure. This new service has a greater intra and post-operative risk as the patient has an obstructed airway, which can cause the patient to go from stable to worse in a matter of seconds. Typically, the patient has failed other treatments, for example continuous positive airway pressure (CPAP) and uvuloplasty before undergoing this procedure.

Also, new code 21199 is more difficult than code 21470 *Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints* (work RVU = 15.34) and code 21045 *Excision of malignant tumor of mandible; radical resection* (work RVU = 16.17). The RUC agreed that the recommended survey work value of 16.00, which was the median survey work value, was appropriate due to the greater intensity and complexity measures and increased risk to the patient.

The RUC recommends a work relative value of 16.00 for code 21199.

Practice Expense Recommendations
The direct inputs were developed by a specialty consensus panel. The specialty society used the E/M standard clinical staff time for the post-operative office visits. The specialty also explained the coordination of appropriate direct inputs. The RUC approved the practice expense inputs for 21199 with minor modifications to the supply list. This service is provided in a facility setting.

Nose Repair (TAB 18)
Presenter: James H. Kelly, MD and Lee Eisenberg, MD

New code 30465 *Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)* was created to describe surgical management of nasal obstruction due to nasal vestibular stenosis. The patient presents with collapsed valves within the nose. This procedure requires two components, revision of the nasal tip with excision of dorsal nasal skin and placement of a support so the nasal tip does not collapse. New code 30465 excludes obtaining a graft, which is obtained from a distal site and is a separately reportable service using the appropriate graft procedure code (20900-20926, 21210). Currently, CPT does not contain a code that accurately describes this service; therefore, the unlisted code 30999 *Unlisted procedure, nose* was reported.

The RUC evaluated the work survey results for code 30465, which had a recommended work survey value of 11.64, which was also the median survey work value. When the RUC compared the new code with the reference service code 30400 *Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip* (work RVU = 9.83), the new code had greater time and complexity and intensity measures, as the patients are generally sicker with comorbid conditions.

The pre- and post-service work for new code 30465 includes extensive patient support in terms of the physical disfigurement that results from the procedure. This new procedure has greater technical difficulties due to the elevation and stabilization of the nasal tip.

Additionally, resection of excessive dorsal skin is performed in conjunction with the repair of the tip ptosis. Due to the significant risk to the patient and the technical difficulty of the procedure, the RUC agreed that the recommended value of 11.64 was appropriate.

The RUC recommends a work relative value of 11.64 for code 30465.

Practice Expense Recommendations
The direct practice expense inputs were developed by a specialty consensus panel. The society used code 30400 as a reference service to determine appropriate direct inputs. The specialty also explained the coordination of care activities required.

The RUC accepted the practice expense direct inputs with minor modifications to the supplies. The specialty society used the E/M standard clinical staff time for their post-operative office visits.

Implantation or Replacement of Osseointegrated Implant Temporal Bone (TAB 19)
Presenters: James H. Kelly, MD and John Niparko, MD

69714
Work Relative Value Recommendations
New code 69714 *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy* was created to describe placement of an osseointegrated device without mastoidectomy to restore hearing sensitivity and speech. Currently, CPT does not contain a code that accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear was reported*.

The RUC compared the work survey results to survey reference code 69632 *Tympanoplasty without mastoidectomy (including canalplasty, atticottomy and/or middle ear surgery, initial or revision; with ossicular chain reconstruction (eg, postfenestration)* (work RVU = 12.75). When evaluating the results of the work survey, new code 69714 has comparable work estimates and intensity and complexity measures. The recommended work relative value for new code 69714 is slightly higher than the reference code 69632, as the intraoperative work for 69714 requires more technical skill to assure the durability of the implant. New code 69714 requires greater mental effort and judgement than the reference service code (69632). Postoperatively, new code 69714 requires more work to monitor the wound and area of the implant. Therefore, the RUC agreed that the recommended work relative value of 14.00, which is also the median survey work value, is appropriate.

The RUC recommends a work relative value recommendation of 14.00 for code 69714.

69715

Work Relative Value Recommendations

New code 69715 *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy* was created to describe placement of an osseointegrated device with mastoidectomy to restore hearing sensitivity and speech. CPT code 69715 involves greater work due to the mastoidectomy that is performed to address the chronic mastoid infections. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

The RUC compared code 69715 to the reference service code 69642 *Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction* (work RVU = 16.84) and noted that the new code 69715 requires greater time and intensity and complexity measures.

The median survey work relative value was 18.25, which the RUC agreed was an appropriate work value given the greater intensity and complexity measures for new code 697X2.

The RUC recommends a work relative value of 18.25 for code 69715.

69717

Work Relative Value Recommendations

New code 69717 *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy* was created to describe replacement of a new integrated implant without performing a mastoidectomy. New code 69717 represents a revision to code 69714, where the implant is removed and replaced. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

When evaluating new code 69717, the RUC compared this work to 69714 and agreed that the intraoperative technical skill was greater for code 69717 than in 69714. The RUC agreed the additional 0.98 RVU's added to the recommended work RVU = (14.00) for code 69714 to calculate a recommended work RVU of 14.98 for 69717 was appropriate. The RUC also compared new code 69717 to the reference service code 69711 *Removal or repair of electromagnetic bone conduction hearing device in temporal bone* (work RVU = 10.44). New code 69717 requires greater time and intensity and complexity measures than the reference service code. The RUC agreed that the recommended work relative value of 14.98, which was also the survey median value was appropriate.

The RUC recommends a work relative value of 14.98 for code 69717.

69718

Work Relative Value Recommendations

New code 69718 *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy* was created to describe replacement of a new integrated implant while performing a mastoidectomy. This code describes the replacement as well as the removal. A separate site needs to be found to place a new device; however the device is placed within in the same surgical field. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

The RUC compared new code 69718 to the reference service code 69642 *Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction* (work RVU = 16.84). The RUC agreed the new code was greater in time and intensity and complexity measures than the reference service code. New code 69718 has a recommended work relative value of 18.50, which the RUC agreed was appropriate.

The RUC recommends a work relative value of 18.50 for code 69718.

Practice Expense Recommendations

The direct practice inputs were developed by a specialty consensus panel. The specialty society used the E/M standard clinical staff time for their post-operative office visits. The RUC approved the recommended inputs with only minor modifications to the supplies. All practice expense recommendations are for the facility setting only.

Speech and Auditory Evoked Potentials Services (TAB 20)

Presenters: James H. Kelly, MD and John Niparko, MD

92585

Work Relative Value Recommendation

The RUC agreed that the physician work for this service has not changed, as the revision does not relate to the physician review and interpretation.

The RUC recommends that the work of 92585 remain unchanged at 0.50 work RVU.

Practice Expense Recommendation

The RUC did approve the recommended inputs for the non-facility setting for 92585, with the deletion of several supplies. There are no direct inputs when the service is performed in a facility setting.

92586

Work Relative Value Recommendation

New code 92586 *Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited* was added to CPT to allow the reporting of state mandated testing for hearing loss in newborns to accurately bill for auditory brainstem response testing (ABRs) performed on infants that may be limited in scope.

There is currently a code 92585 for all ABRs; however, limited ABRs are being increasingly performed as part of mandated infant hearing testing by the states. The only way an audiologist can bill for these services is to append the modifier –52 (reduced services), which is unrecognized by most payers. As this new service does not typically require review by a physician, there is no physician work.

The RUC recommends no physician work relative values for code 92586.

Practice Expense Recommendation
The RUC recommends no direct practice expense inputs for 92586 as it is only performed in the facility setting.

Transmyocardial Laser Revascularization (TAB 21)
Presenter: Sidney Levitsky, MD
Reviewed by Facilitation Committee 3

New code 33141 *Transmyocardial laser revascularization, by thoractomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)* was created to describe transmyocardial revascularization (TMR) performed as a useful alternative or adjunct to coronary artery bypass grafting. It is especially pertinent to patients who are not candidates for coronary artery bypass grafting due to non-graftable vessels.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

There is no pre and post-service work associated with this service. There is only intra-service work associated with CPT code 33141, as code 33141 is an add-on code and is always reported in addition to another code. It was recognized that the only way to make the determination that the vessel was unsuitable for replacement would be after dissection and evaluation, and that such work would not be covered under the vessel graft service. Also, it was recognized that preparing the TMR equipment for surgical use was not included in the graft service.

In determining the intra-service work value, the RUC reviewed three activities:
1) For the first step, the RUC reviewed the differential RVU's from the CABG (vein) codes for 33510 *Coronary artery bypass, vein only; single coronary venous graft* (work RVU = 25.00), 33512 *Coronary artery bypass, vein only; three coronary venous grafts* (work RVU = 27.40), 33513 *Coronary artery bypass, vein only; four coronary venous grafts* (work RVU = 29.67), and 33514 *Coronary artery bypass, vein only; five coronary venous grafts* (work RVU = 31.95). The average differential between respective codes is 2.28 (i.e, the incremental work of dissection and replacement of a single vessel). This recognizes the incremental value of dissecting down to the vessel. The RUC agreed that for dissecting down to a vessel and then evaluating that the vessel could not be replaced, half of 2.28 (1.14) was an appropriate value.

2) For the second step, the RUC was advised that it takes approximately 20 minutes to prepare the TMR equipment for surgical use, a time component that was not considered by the surveyors. The value of this 20 minutes waiting for the equipment with a patient with an open chest and on bypass, was deemed to be similar to a little less than a half hour of critical care (1.80), and attributed 1.4 work RVU's for this element of work.

3) The Committee deemed that the 30 minutes of actual intra service time was equal to a half- hour of critical care (1.8 work RVU's) plus 0.5 work RVU's for using the laser for a total of 2.3 work RVU's.

The RUC then added these three increments of 1.14 (dissecting down to the vessel) + 1.40 (20 minutes prepare the TMR equipment) + 2.30 (actual procedure time of 30 minutes using the laser) = 4.84.

The RUC recommends a work relative value of 4.84 for code 33141.

Practice Expense Recommendations
This add-on code is only performed in a facility setting.

The RUC recommends no direct practice expense inputs.

Repair of Intracranial Aneurysm (TAB 22)
Presenters: Robert E. Florin, MD

61700
Work Relative Value Recommendation
The RUC recommends that existing code 61700 *Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation* (work RVU = 50.50) be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

61697
Work Relative Value Recommendation
The RUC recommends that new code 61697 *Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation* be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

Practice Expense Recommendation
The RUC recommends a crosswalk of the PE inputs for 61697 from 61700.

61702
Work Relative Value Recommendation
The RUC recommends that existing code 61702 *Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation* (work RVU = 48.41) be

an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

61698

Work Relative Value Recommendation

The RUC recommends that new code 61698 *Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation* be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

Practice Expense Recommendations

The RUC recommends a crosswalk of the PE inputs for 61698 from 61702.

Reprogramming of Programmable CSF Shunt (TAB 23)
Presenter: Richard Boop, MD and Greg Przybylski, MD
Reviewed by Facilitation Committee 1

New code 62252 *Reprogramming of programmable CSF shunt* was created to describe non-invasive changes in the pressure settings of programmable cerebrospinal fluid (CSF) shunts. The shunt is typically programmed through the skin using an electromagnetic current. Currently, CPT does not contain an existing CPT code that accurately identifies this service; therefore the unlisted code 95999, *Unlisted neurological or neuromuscular diagnostic procedure* was reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee 1 reviewed this issue and presented the following information.

The physician work involved in new code 62252 involves the reading of the setting of a CSF shunt valve implanted beneath the scalp. To ensure exact adjustment of the shunt valve, the physician performs specific patient positioning and x-rays before and after adjustment of the shunt valve in which the radiological services are not separately reportable.

The intra-service work for new code 62252 involves the reprogramming of the CSF shunt valve by using a hand-held electronic transmitter, as well as positioning and x-raying the patient in order to ensure the valve has been set correctly. The associated risk is high, as sudden death may occur and the setting of the valve correctly is very important to assure there is the desired pressure. The RUC adjusted the intra-service time from 15 minutes to 20 minutes to reflect the work involved for the patient positioning and x-ray time before and after shunt programming and to ensure correct valve setting.

The RUC adjusted the pre-service time from 10 minutes to 15 minutes, with the understanding that the reference code *93735 Electronic analysis of single 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); with reprogramming (work RVU = 0.74) has similar physician work involved. The RUC agreed the post-service time was appropriate at 10 minutes for dictation, documentation, phone calls, and discussion with the family.

The RUC came to a consensus that new code 62252 most closely resembles reference service code 93735 *Electronic analysis of single 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); with reprogramming* (work RVU = 0.74) instead of 93738 *Electronic analysis of single or dual chamber pacing cardioverter-defibrillator only (interrogation, evaluation of pulse generator status); with reprogramming* and because of this change, it was agreed that a work RVU of 0.74, rather than the specialty society recommended value of 0.92, was appropriate.

The RUC recommends a work relative value of 0.74 for code 62252.

Practice Expense Recommendation
The RUC recommends direct inputs for services performed in the non-facility setting. The RUC increased the pre-service clinical staff time from 28 to 35 minutes and approved the standard list of supplies and equipment.

Percutaneous Vertebroplasty (TAB 25)
Presenters: J. Arliss Pollock, MD; James P. Borgstede, MD; Greg Przybylski, MD; and Robert L. Vogelzand, MD
Reviewed by Facilitation Committee 2

22520
Work Relative Value Recommendations
New code 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic* was created to describe minimally invasive vertebroplasty in the thoracic vertebrae. Vertebroplasty is the percutaneous skeletal fixation of a collapsed vertebral body, with access into the vertebral body achieved using radiologic imaging to access the specific vertebra and to monitor the injection of polymethylmethacrylate. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC discussed the pre-service time of 60 minutes for new code 22520 and agreed the time was appropriate. The RUC also agreed that the intra-service time of 80 minutes for code 22520 was appropriate.

The RUC discussed the post-service time on the day of the procedure and agreed that the discharge management was appropriate. However, the 99231 Hospital visit time and work should be deducted from the total time and work, as the patient is usually discharged on the same date. The RUC agreed that the service should include one 99213 office visit, not the two visits as indicated in the survey. The RUC deducted the hospital visit and one office visit to arrive at a work value of 8.91 for code 22520.

The RUC recommends a work relative value of 8.91 for code 22520.

Practice Expense Recommendations

This service is only provided in a facility setting; therefore, the RUC recommends that the E/M package for clinical staff time, supplies and equipment for the 99213 level of office visit be included in the post-operative period for code 22520. The E/M standard package for 99213 is listed below:

Clinical Labor	RN/LPN/MA	36 minutes
Medical Supplies:		
Drape Sheet		1 item
Exam table paper		7 feet
Pillow case		1 item
Gloves, non-sterile		2 pair
Otoscope speculum disposable		1 item
Patient education booklet		1 item
Patient gown, disposable		1 item
Swab, alcohol		2 items
Thermometer probe cover, disposable		1 item
Tongue depressor		1 item
Overhead Equipment:		
Exam table		
Crash cart, no defibrillator		
Otoscope-ophthalmoscope		

This service is only provided in a facility setting, therefore, the RUC agreed that 1 post operative visit was appropriate within the global period.

22521

Work Relative Value Recommendations

New code 22521 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar* was created to describe minimally invasive vertebroplasty in the lumbar vertebrae. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC discussed the pre-service time of 60 minutes for new code 22521 and agreed the time was appropriate. The RUC also agreed that the intra-service time of 80 minutes for code 22521 was appropriate. The RUC discussed the post-service time on the day of the procedure and agreed that the discharge management was appropriate.

However, the 99231 Hospital visit time and work should be deducted from the total time and work, as the patient is usually discharged on the same date. The RUC agreed that the service should include one 99213 office visit, not the two visits as indicated in the survey.

The RUC deducted the hospital visit and one office visit to arrive at a work value of 8.34 for code 22521.

The RUC recommends a work relative value of 8.34 for code 22521.

Practice Expense Recommendations
This service is performed only in a facility setting; therefore, the RUC recommends that the E/M package for clinical staff time, supplies and equipment for the 99213 level of office visit be included in the post-operative period for code 22521. The E/M standard package for 99213 is listed below:

Clinical Labor	RN/LPN/MA	36 minutes
Medical Supplies:		
Drape Sheet		1 item
Exam table paper		7 feet
Pillow case		1 item
Gloves, non-sterile		2 pair
Otoscope speculum disposable		1 item
Patient education booklet		1 item
Patient gown, disposable		1 item
Swab, alcohol		2 items
Thermometer probe cover, disposable		1 item
Tongue depressor		1 item
Overhead Equipment:		
Exam table		
Crash cart, no defibrillator		
Otoscope-ophthalmoscope		

This service is only provided in a facility setting, therefore, the RUC agreed that one post operative visit was appropriate within the global period.

22522
Work Relative Value Recommendations
New 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)* was created to describe minimally invasive vertebroplasty in additional lumbar or thoracic vertebrae.

Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC agreed that code 22522 should represent an average of half (50%) of the recommended work RVU of 22520 (4.45), and 22521 (4.17), which is a total of 4.31 work RVU's.

The RUC recommends a work relative value of 4.31 for code 22522.

Practice Expense Recommendations
There are no direct practice expense inputs, as code 22522 is on add-on code performed only in a facility setting.

76012
Work Relative Value Recommendations
New code 76012 *Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under fluoroscopic guidance* describes the radiologic portion of using fluoroscopy to access the specific vertebra, place the needle and monitor the injection of polymethylmethacrylate.

The survey median for code 76012 was 1.31. The RUC agreed that this value was appropriate for the work involved. The RUC compared new code 76012 to the reference service code 75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation,* which has the same intra-service time. The RUC agreed that the physician pre-service time for 76012 should be deleted, as it overlaps with the percutaneous vertebroplasty codes. The RUC recommends that the survey work relative value median be approved for 1.31.

The RUC recommends a work relative value of 1.31 for code 76012.

Practice Expense Recommendations
There are no direct practice expense inputs as this service is only performed in a facility setting.

76013
Work Relative Value Recommendations
New code 76013 *Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under CT guidance* describes the radiologic portion of using CT guidance to access the specific vertebra, place the needle and monitor the injection of polymethylmethacrylate.

The RUC compared code 76013 and agreed the intensity and number of films to be taken are greater in code 76013 than 76012. The RUC agreed that the relativity of the

original specialty recommendations presented for codes 76012 (1.16) and 76013 (1.22) be maintained and therefore; the RUC agreed that a work relative value of 1.38 was appropriate.

The RUC recommends a work relative value of 1.38 for code 76013.

Practice Expense Recommendations
There are no direct practice expense inputs, as this service is performed only in a facility.

Endovascular Graft for Abdominal Aortic Aneurysm (TAB 26)
Presenters: Gary Seabrook, MD; Robert Vogelzang, MD; and James P. Borgstede, MD
Reviewed by Facilitation Committee 3

New CPT codes were created to describe procedures related to endovascular abdominal aortic aneurysm repair. New codes 34800-34826 describe the placement of the endovascular graft for abdominal aortic aneurysm repair under fluoroscopic guidance. New codes 34830-34832 describe open repair of an infrarenal aortic aneurysm following unsuccessful endovascular repair. Two new codes 75952 and 75953 were created to describe fluoroscopic guidance in conjunction with endovascular aneurysm repair.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

The Committee considered whether or not the Societies' description of the coding for services adjunctive to the respective presented services was consistent with current accepted coding practices. The Committee was advised that the society's description was correct. However, it was suggested that the CPT introductory notes to "Endovascular Repair of Abdominal Aortic Aneurysm" be revised to better clarify the appropriate coding of relevant multiple services provided in a single session.

The RUC considered the format of the survey instruments utilized in the presentation. It was clarified that in each case, the surveys included CPT code, global period designation, CPT descriptor, vignette, and descriptions of pre-service work, intra-service work inclusions, post-work, and services that could be separately billable and therefore not included in the surveyed service. The clinical description of pre-intra-post-service work was not provided to the surveyees. There was discussion of possible effects of the statement of the excluded services. It was the consensus of the committee that given the intricacies of the accepted coding for these types of services, stimulating the list of excluded services better ensured that the work of the respective presented service was appropriately surveyed.

34800
New code 34800 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis* was created to describe deployment of an

aorto-aortic tube prosthesis. The RUC reviewed codes 35102 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)* (work RVU = 30.76; global 090) and reference service code 35081 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm and associated occlusive disease, abdominal aorta* (work RVU = 28.01; global 090) and determined a difference of 2.75 work RVU's for involvement of iliac vessels. This was compared to the differential of 2.25 between 34800 and 34802. The RUC agreed that this differential was appropriate.

The RUC recommends a work value of 20.75 for code 34800.

34802

New code 34802 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)* describes the deployment of a modular bifurcated endovascular prosthesis. When performing this service, there is a need to access the femoral artery (34812), which is the open femoral artery exposure. Imaging 75952 constitutes the imaging of all the services (e.g., ballooning, stenting) and is only reported one time.

The recommended work value for code 34802 is 23.00. The pre-service time (135 minutes) is relatively higher than the reference service code 35102 (95 minutes), as review of CT scans and aortograms is performed, measurement of the diameter and length of the graft is needed and ordering of the graft is performed, which is included in the new code and is not captured with a separate E/M code or other service code.

The RUC agreed that CPT code 35102 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft;* (work RVU = 30.76; global 090) was a reasonable reference code for this service. The RUC discussed the service times for reference service code 35102 (180 minutes) and noted they are higher than compared to the new code 34802 (150 minutes). The RUC recognized that the societies recommended the 25th percentile work RVU = 23.00 based upon two validation methodologies.

The RUC agreed that the recommended work value of 23.00 was appropriate.

The RUC recommends a work relative value of 23.00 for code 34802.

34804

New code 34804 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis* was created to describe deployment of a unibody bifurcated endovascular prosthesis.

The specialty society presented the survey 25th percentile work RVU of 23.00. The RUC was comfortable that this service was similar in work to 34802. The RUC agreed that this was an appropriate work relative value for this service.

The RUC recommends a work relative value of 23.00 for code 34804.

34808

New code 34808 Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure) *was created to describe endovascular placement of an iliac artery occlusion device.*

The RUC determined that this code would not be independently performed. **Therefore, the RUC recommends that it be designated a ZZZ global.** The RUC reviewed code 37206 Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure) (work RVU = 4.13; global ZZZ) and agreed that it was comparable to 34808.

The RUC recommends a work value of 4.13 for code 34808.

34812

New code 34812 *Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral* was created to describe open surgical exposure of the femoral artery via a unilateral groin incision to expose a site on the artery through which catheters, guidewires, and endovascular prosthetic components are delivered.

After much discussion, the RUC deemed that this service was very similar in work to 33970 *Insertion of intra-aortic balloon assist device through the femoral artery, open approach* (work RVU = 6.75; global 000) and that the 090 global designation was inappropriate for 34812.

With reduction to a 000 global, the RUC recommends the work relative value of 6.75 for code 34812.

34813

New code 34813 *Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)* was created to describe the open bilateral femoral artery exposure for the deployment of the endovascular prosthesis. The RUC reviewed code 35661 *Bypass graft, with other than vein; femoral-femoral* (work RVU = 13.81; global 090) and reduced this value by 6.75 work RVU for one groin and half of 6.75 (3.38) for the second groin to arrive at a work value of 3.68. In addition, the combination of two artery exposures plus one femoral-femoral graft has very close work equivalent to the reference service code 35656 *Bypass graft, with other than vein; femoral-popliteal.* Given these calculations, the RUC agreed comfortable with the originally recommended value of 4.80.

The question was raised regarding what would be done if 34812 and 34813 were performed without introduction of a device. The RUC agreed that there should be a CPT note that indicates that if these are performed without the delivery of an endovascular prosthesis, there should be an appropriate cross reference in CPT (perhaps directing to 35661). The presenters agreed that it would be appropriate to ask for such an editorial change.

The RUC recommends a work relative value of 4.80 for code 34813. The RUC recommends that CPT review appropriate guidelines when 34812 and 34813 are performed without introduction of an endovascular prosthesis.

34820

New code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision; unilateral* was created to describe the open surgical exposure of the iliac arteries via a retroperitoneal or abdominal approach. This procedure may be performed when the femoral arteries are diseased or inadequate diameter to allow passage of the large endovascular introducer sheaths.

The RUC compared code 49010 *Exploration, retroperitoneal area with or without biopsy(s) (separate procedure*) (work RVU = 12.28; global 090) and agreed that this service was roughly comparable to the work of 34820. However, the RUC agreed that 34820 would be better designated as a 000 global and decided to delete the after service care resulting in a work RVU of 9.75.

The RUC recommends a work relative value of 9.75 for code 34820. The Committee also recommends a 000 global.

34825

New code 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel* was created to describe placement of a proximal or distal extension prosthesis in an initial vessel for endovascular repair of an infrarenal abdominal aortic aneurysm. The RUC agreed with the survey median, of which 54 vascular surgeons indicated the appropriate work relative value should be 12.00.

The RUC recommends a work relative value of 12.00 for code 34825.

34826

New code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; each additional vessel (List separately in addition to code for primary procedure)* was created to describe placement of a proximal or distal extension prosthesis in each additional vessel, for endovascular repair of an infrarenal abdominal aortic aneurysm. The RUC compared new code 34826 to the reference service code 37208 *Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure)* and noted that the intra-service time is identical.

However, new code 34826 has greater time, and intensity and complexity measures than the reference service code.

The RUC identified that this would only be performed with 34825 and agreed the recommended work value of 4.13 was appropriate for code 34826.

34830

New code 34830 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed.

The RUC compared 35081(work RVU = 28.01) and 35082 *Direct repair or aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU = 36.35) and agreed that the work of 34830 was roughly in the mid-range of these two services.

The RUC recommends a work relative value of 32.59 for code 34830.

34831

New code 34831 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed.

The RUC compared reference service codes 35081 (work RVU = 28.01) and 35102 (work RVU = 30.76) and calculated a difference of 2.75 work RVU's between these two codes. When this was added to 34830, the resulting work RVU was 35.34.

The RUC recommends a work relative value of 35.34 for code 34831.

34832

New code 3483*2 Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed. The RUC determined that the work of 34832 was equivalent to 34831.

Therefore, the RUC recommends a work relative value of 35.34 for code 34832.

75952

New code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* was created to describe the radiological supervision and interpretation which includes angiography of the aorta and

its branches for diagnostic imaging prior to deployment of the endovascular device(s), fluoroscopy for guidance in the delivery of the endovascular components and subsequent arterial imaging to confirm appropriate position of the graft, detect endoleaks, and evaluate the status of the runoff vessels.

The RUC was concerned that the low number of survey responses from Interventional Radiologists might have inappropriately skewed the survey results. Therefore, the RUC agreed that any value approved should be an interim value until the Interventional Radiologists conduct another survey.

Based upon this concern, the RUC decided to take the mid-point value between the median of 3.50 work RVU and the Society's recommended work value of 4.50.

The RUC recommends an interim work relative value of 4.00 for code 75952.

75953

New code 75953 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm, radiological supervision and interpretation* describes the radiological supervision and interpretation for the placement of the proximal or distal extension prosthesis.

The RUC noted that the Society's presented a recommendation of 1.36 work RVU, which was less than their 25th percentile.

The Committee recommends a work value of 1.36 for code 75953.

Practice Expense Recommendations

The RUC approved a Facilitation Committee report that reviewed the direct inputs for the new endovascular graft codes. The RUC agreed to a standard pre-service time of 45 minutes for the 090 day global codes 34800, 34802, 34804, 34825 and 34830, 34831, and 34832. The RUC then assigned the standard E/M clinical staff times for the number and levels of office visits for each of these codes. In addition, these codes also were assigned the standard basic post operative incision care kit for the first office visit and then the standard minimum E/M supply packaged for each office visit. Since these procedures are performed in the facility setting, the RUC did not assign any procedure specific equipment. However, the standard E/M overhead equipment was included.

Percutaneous Management of Dialysis Graft/Fistula (TAB 27)
Presenters: James Borgstede, MD, and Robert Vogelzang, MD
Reviewed by Facilitation Committee 3

New code 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* was created to describe percutaneous treatment of a thrombosed hemodialysis graft or fistula. Currently, CPT does not contain a code that accurately describes this service; therefore the unlisted code 37799 *Unlisted procedure, vascular surgery* was reported.

The RUC did not accept the initial specialty society work relative value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

The RUC evaluated new code 36870 *Thrombectomy, percutaneous arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* which had a recommended work RVU of 6.85. This recommended value is also the survey median work value.

The RUC identified that there are three services that will always be provided together; new code 36870 (Societies' recommended work RVU of 6.85; 090 global), 36145 *Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)* (work RVU = 2.01), and 75790 Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation (work RVU = 1.84).

36870	*6.85*
*36145 (2.01 * .5)*	
(50% reduction)	*1.00*
75790	*1.84*
	9.69

The RUC agreed that the complete service should be directly comparable to the open code. The RUC evaluated code 36831 *Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft* (work RVU = 8.00; 090 global). The RUC; therefore, reduced the open code's total work RVU of 8.00 by 1.00 (50% of 36145) and 1.84 (75790), with the resulting work RVU = 5.16.

The RUC also reviewed code 36860 *External cannula declotting; without balloon catheter* (work RVU = 2.01; 000 global) and 35473 *Transluminal balloon angioplasty, percutaneous; iliac* (work RVU = 6.04; 000 global) and determined that this 36870 was roughly in this range. The Societies' agreed to a value of 5.16, recognizing that it also incorporated a 090 global.

The RUC recommends a work relative value of 5.16 for code 36870.

Practice Expense Recommendations

The RUC approved a Facilitation Committee report that reviewed the direct inputs for Percutaneous Management of Dialysis Graft/Fistula when performed in a non-facility setting. The RUC agreed with the facilitation committee that a pre-service time of 15 minutes, a service period time of 115 minutes, and post service time of 5 minutes, was appropriate for this procedure. One physician 99212 office visit is included in the global period, with the specialty noting that this visit would require less time than the standard 99212 and recommends 16 minutes of clinical staff time. Revised medical supplies and equipment were also submitted by the facilitation committee and approved by the RUC.

Naso-or-Oro-gastric Tube Placement
Presenters: James P. Borgstede, MD and Joel Brill, MD

Work Relative Value Recommendation
New code 43752 *Naso- or oro-gastric tube placement, necessitating physician skill* was created to describe the instance wherein naso-gastric tube placement required additional skill or involved additional risk in which a physician's skill is required. Generally, these services are performed by non-physician clinical staff; however, if multiple attempts taken by non-physician personnel to place the tube were unsuccessful, this would then require a physician's skill to place the tube in which CPT currently does not contain a code.

The RUC has not developed a specific work relative value recommendation for new CPT code 43752 *Naso- or oro-gastric tube placement, necessitating physician skill* and had requested that the CPT Editorial Panel reconsider the nomenclature for this service.

The Editorial Panel did add the note under CPT 44500 *Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)* to specify that NG tube placement be reported utilizing the new code 43752; however, the CPT Editorial Panel did not revise the nomenclature for 43752.

The RUC will reconsider this issue at the February 2001 meeting and will forward any recommendations to HCFA at that time.

GI Endoscopy Procedures (TAB 29)
Presenters: Joel Brill, MD
Reviewed by Pre-Facilitation Committee 3

The specialty societies presenting relative value recommendations for Gastrointestinal Endoscopy Procedures at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

In developing interim recommendations for these new endoscopy procedures, the RUC reviewed the current relationships within existing codes and determined an appropriate increment for both the transendoscopic ultrasound and the needle/aspiration/biopsy. The RUC recommends the following interim work RVUs:

43200	*Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	*1.59*
43202	*with biopsy, single or multiple*	*1.89*
43231 (Y1)	**Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination**	**4.09**

43232 (Y2)	**with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**	**4.71**
43235	*Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	*2.39*
43259	*with endoscopic ultrasound examination*	*4.89*
43242 (Y3)	**with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**	**5.51**
43240 (Y4)	**with transmural drainage of pseudocyst**	**7.39**
45330	*Sigmoidoscopy, flexible; diagnostic, with or without collection of of specimen(s) by brushing or washing (separate procedure)*	*.96*
45341 (Y5)	**with endoscopic ultrasound examination**	**3.46**
45342 (Y6)	with transendoscopic ultrasound-guided intramural or **transmural fine needle aspiration/biopsy(s)**	4.08

The rationale for each is as follows:

Y1 = 43200 (1.59) + 2.50 (ultrasound increment)* = 4.09

Y2 = Y1 (4.09) + .62 (biopsy increment)** = 4.71

Y3 = 43259 (4.89) + .62 (biopsy increment)** = 5.51

Y4 = The RUC recommends that this service is equivalent to code 43262 *Endoscopic retrograde cholangio-pancreatography (ERCP); with sphincterotomy/papilotomy* (work RVU = 7.39*). The specialty's survey data indicated that the total time for this new CPT code is 130 minutes, which is directly comparable to the Harvard total time of 137 minutes for 43262.*

Y5 = 45330 (.96) + 2.50 (ultrasound increment)* = 3.46

Y6= Y5 + .62 (biopsy increment)** = 4.08

*Ultrasound increment = 43259 (4.89) – 43235 (2.39) = 2.50

**Biopsy increment = Blend between 19291 *Preoperative placement of needle localization wire, breast; each additional lesion* (0.63) and the increment between 31629 *Bronchoscopy, (rigid or flexible); with transbronchial needle aspiration biopsy* (work RVU = 3.37) and 31622 *Bronchoscopy (rigid or flexible); diagnostic with or without cell washing (separate procedure)* (work RVU = 2.78) of .59.

Practice Expense Recommendation
The following applies to codes 43231, 43232, 43242, 43240, 45341, 45342 (Y1-Y6). Practice Expense inputs agreed upon at the pre-facilitation meeting were as follows

35 minutes pre-service time RN/MA/LPN
10 minutes coordination of care RN/MA/LPN
10 minutes post-telephone calls RN/MA/LPN

No Medical Supplies
No Equipment
These services are performed in a facility setting.

Endoscopic Enteral Stenting (TAB 30)
Presenters: Joel Brill, MD
Reviewed by Pre-Facilitation Committee 3

The specialty societies presenting relative value recommendations for Endoscopic Enteral Stenting at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

In developing interim RUC recommendations for these codes, the committee established an increment that could be applied to each base code for the "transendoscopic stent placement (includes predilation)" component. The RUC determined this increment by adding a component for placement of stent with a component to represent the work inherent in utilizing a guidewire, as follows:

43219	*Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent*	2.80
43200	*Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	1.59
	Increment for Placement of Stent	**1.21**
43226	*Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire*	2.34
43200	*Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	1.59
	Increment for Guidewire	***0.75***
	Increment for "transendoscopic stent placement (includes predilation)"	***1.96***

Based on this increment, the RUC recommends the following interim work relative value recommendations:

44397

New code 44397 *Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)* was created to describe stent placement via colonoscopy through a stoma, for duodenal and colonic obstructions or with gastric outlet strictures caused by malignant neoplasms. Stent placement also provides a solution for relieving large bowel obstruction prior to colectomy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Colonoscopy through stoma; with transendoscopic stent placement (includes predilation) = 44388 *Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 2.82 + 1.96 = **4.78**.

45327

New code 45327 *Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation*) was created to describe stent placement during a rigid proctosigmoidoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation) = 45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 0.70 + 1.96 = **2.66**.

45345

New code 45345 *Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)* was created to describe stent placement during a flexible sigmoidoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation) = 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 0.96 + 1.96 = **2.92**.

45387

New code 45387 *Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)* was created stent placement during a flexible colonoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation) = 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon depression (separate procedure)* 3.70 +1.96 = **5.66**.

Other New Codes:
The CPT Editorial Panel approved new codes (43256, 44370, 44379 and 44383) at the May 2000 meeting. The RUC; therefore, did not have the opportunity to review these services. The RUC will forward recommendations after February 2001.

Practice Expense Recommendation
The following applies to codes 44397, 45327, 45345, and 45387.
Practice Expense inputs agreed upon at the pre-facilitation meeting were as follows:

35 minutes pre-service time RN/MA/LPN
10 minutes coordination of care RN/MA/LPN
10 minutes post-telephone calls RN/MA/LPN
No Medical Supplies
No Equipment
These services are performed in the facility setting.

Cutaneous Electrogastrography Provocative Testing (TAB 31)
Presenters: Joel Brill, MD

91132
New code 91132 *Electrogastrography, diagnostic, transcutaneous* was created to describe a procedure performed for diagnosing disorders of gastric motility which frequently involves the electrical activity of the stomach. An EGG device is positioned on the abdomen and usually placed over the epigastrium and an EGG is performed.

The RUC recommends that CPT code 91132 (VV1) be carrier-priced as currently very few physicians in the United States are performing these services. After these services become more widespread, the specialty societies will present relative value recommendations to the RUC.

91133
New code 91133 *Electrogastrography, diagnostic, transcutaneous; with provocative testing* was created to describe a procedure performed for diagnosing disorders of gastric motility which frequently involves the electrical activity of the stomach. New code 91133 includes provocative testing.

The RUC recommends that these services be carrier-priced as currently very few physicians in the United States are performing these services. After these services become more widespread, the specialty societies will present relative value recommendations to the RUC.

Photodynamic Therapy (TAB A)
Presenters: Joel Brill, MD
Reviewed by Pre-Facilitation Committee 3

96570

Work Relative Value Recommendations

CPT code 96570 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)* was created to describe photodynamic therapy used for treatment in esophageal cancer.

CPT code 96570 is used to report the application of a light source to activate the photoactive drug, for the first 30 minutes. A continuous wave of argon-pumped dye laser is used to deliver a red light to the target tissues containing the photoactive drug. Upon application of the light, the photoactive drug produces single oxygen destroying the cells in which the drug has collected.

The specialty societies presenting relative value recommendations for Photodynamic Therapy at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

These codes were added to CPT in 2000 and therefore, HCFA has already established relative values for these services. The RUC reviewed the current work relative values for these add-on codes and thought that they were reasonable and agreed that they be proposed as interim RUC recommendations.

96570 (XX1)	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately; in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)	**1.10**

Practice Expense Recommendations

As CPT code 96570 is an add-on code with a global period of ZZZ, there are no practice expense inputs.

96571

Work Relative Value Recommendations

New code 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)* was created to describe photodynamic therapy used for treatment in esophageal cancer. Code 96571 is used to report the application of a light source to activate the photoactive drug for each additional 15-minutes after the first initial 30 minutes.

A continuous wave of argon-pumped dye laser is used to deliver a red light to the target tissues containing the photoactive drug. Upon application of the light, the photoactive drug produces single oxygen destroying the cells in which the drug has collected.

The specialty societies presenting relative value recommendations for Photodynamic Therapy at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

These codes were added to CPT in 2000 and therefore, HCFA has already established relative values for these services. The RUC reviewed the current work relative values for these add-on codes and thought that they were reasonable and agreed that they be proposed as interim RUC recommendations.

96571 (XX2) each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus) **0.55**

Practice Expense Recommendation
As CPT code 96571 is an add-on code with a global period of ZZZ, there are no practice expense inputs.

Medical Nutrition Therapy (TAB B)
This issue has been referred back to the CPT Editorial Panel for further review.

Collection of blood specimen from venous access device (TAB C)
Presenters: John Pippen, MD

Work Relative Value Recommendations
New code 36540 *Collection of blood specimen from a partially or completely implantable venous access device* was created to describe the collection of blood specimens from an implantable venous access port. Venous access ports are implanted in patients who require recurrent venous access for therapeutic intervention; however, these access ports may also be used to draw blood for laboratory testing. Currently, CPT does not contain an existing code that describes venous access for collection of a blood specimen from an implantable access port.

The RUC agreed with the specialty society that there is no physician work involved in the new code 36540 *Collection of blood specimen from a partially or completely implantable venous access device.*

Practice Expense Recommendations
The RUC recommends that the practice expense inputs for new code 36540 be forwarded to HCFA with no clinical time. The RUC agreed that for this new code to be performed in a non-facility setting, the attached medical supplies and equipment were necessary.

Computed Tomography Angiography (TAB D)
Presenters: James P. Borgstede, MD and J. Arliss Pollock, MD

Work Relative Value Recommendations
Although the CPT Editorial Panel approved eight new codes for computed tomographic angiography, the radiologists presented recommendations for only two codes in this family. The RUC, therefore, is presenting recommendations for the following two codes in this series of eight codes.

70496
New code 70496 *Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s), including image post-processing* was created to describe CTA of the head without contrast materials followed by contrast material. This is a new technique used for imaging vessels. The information gathered from CTAs is used in the evaluation of vascular anatomy, vascular disorders such as aneurysms, stenoses, cases of suspected vascular trauma, and in the follow-up of organ transplantation.

70496 (SS1) Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s), including image post-processing **1.75**

70498
New code 70498 *Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s), including image post-processing* was created to describe CTA of the neck without contrast materials followed by contrast material. This is a new technique used for imaging vessels.

70498 (SS2) Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s), including image post-processing **1.75**

The specialty society may present recommendations on the remaining six codes from this family at the February 2001 RUC meeting. The RUC will forward any resulting recommendations to HCFA after this meeting.

The RUC agreed that these services were most similar in work to CPT code 70541 *Magnetic resonance angiography, head and/or neck, with or without contrast material(s)* (work RVU = 1.81). The specialty's survey data indicated that these new services require 37-38 minutes of physician time. This is comparable to the previous RUC survey total time for 70541 of 40 minutes. The patients who receive CTA are patients that typically are unable to utilize the MRA, as they may have a pacemaker or aneurysm clip or are claustrophobic or unwilling to remain motionless.

The RUC also reviewed the relationship of these new services to the existing CT codes, including 70470 *Computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27) and

70492 *Computerized axial tomography, soft tissue neck; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.45) and agreed that these CTA services require significantly more physician time than traditional CT as there are more studies to review.

Practice Expense Recommendations
The RUC agreed that the list of direct practice expenses accurately reflected the resources required for each of the procedures, 70496 and 70498, in the non-facility setting.

Magnetic Resonance Imaging (TAB E)
Presenters: James P. Borgstede, MD and J. Arliss Pollock, MD
Reviewed by Facilitation Committee 4

Work Relative Value Recommendations
The CPT Editorial Panel has revised five Magnetic Resonance Imaging (MRI) codes and added ten codes to specify MRI without contrast; with contrast; and without contrast material, followed by contrast material(s) and further sequences.

The specialty has only presented recommendations for three codes that represent MRI for orbit, face, and neck.

The specialty society may present recommendations on the remaining twenty-one MRI codes at the February 2001 RUC meeting. The RUC will forward any resulting recommendations to HCFA after this meeting.

The RUC understands that when these MRI codes were evaluated, gadolinium (contrast material) was not in widespread use and therefore, code 70540 *Magnetic resonance (eg, proton) imaging, orbit, face, and neck* (work RVU = 1.48) was valued assuming "without contrast material." The RUC recommendations, therefore, that revised 70540 be considered editorial and reflect no change in work.

The RUC did not agree with the increment proposed by the specialty for adding "contrast materials" and "without contrast materials, followed by contrast material(s) and further sequences." The RUC recommends that an increment of .30 to reflect the additional physician work in performing the MRI with contrast materials. The RUC determined that the current increment between codes 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.48) and 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material* (work RVU = 1.78) is appropriate. This increment of .30 should be added to 70540 to determine a recommended work relative value of 1.78 for 70542 *Magnetic resonance (eg, proton) imaging, orbit, face, and neck; with contrast material.*

Code 70543 *Magnetic resonance (eg, proton) imaging, orbit, face and neck; without contrast material, followed by contrast material(s) and further sequences should be valued at* 70540 (1.48) and ½ 70542 (1.78) for a recommended work RVU of 2.36.

This is also consistent with the increment between codes 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.48) and 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU = 2.36).

Practice Expense Recommendations
The RUC agreed with the facilitation committee's recommendation that all three codes, 70540, 70542, and 70543, be cross walked to existing CPEP inputs for codes 70551, 70552, 70553.

Magnetic Resonance Angiography (Head and Neck) (TAB F)
Presenters: J. Arliss Pollock, MD and James. P. Borgstede, MD
Reviewed by Facilitation Committee 4

Work Relative Value Recommendations
The CPT Editorial Panel deleted the current code 70541 *Magnetic resonance angiography, head and/or neck, with or without contrast material(s)* (work RVU = 1.81) and replaced this code with six new codes to differentiate magnetic resonance angiography (MRA) for head and MRA for neck, and to indicate performance of studies with contrast. Distinct codes to describe the anatomical sites is justified as these two services, if done at the same patient encounter, require removal of the patient from the magnet bore, placement of separate MR imaging coils for the evaluation of distinct anatomic regions, and re-centering the patient, including new scout sequences. Two separate studies are produced and must be interpreted and reported separately.

In addition, no current codes exist for the performance of these studies with the dynamic administration of contrast materials, which was not generally utilized for this procedure when the code was originally developed in 1994. The RUC agreed with this argument and would like to emphasize to HCFA that these new codes report new technology, therefore, work neutrality should not be an issue.

The RUC reviewed the existing RUC survey time for code 70541 of 41 minutes and compared this to the surveyed time for the six new services. The RUC also reviewed the current work relative value for 70541 of 1.81 and agreed that 1.20 was reasonable for each anatomical site (head and neck) with or without contrast. Based on this review, the RUC agreed that the specialty society recommendations were appropriate as listed below:

70544	MRA, head; without contrast material	1.20
70545	with contrast material (s)	1.20
70546	with contrast, followed by contrast	1.80
70547	MRA, neck; without contrast material	1.20
70548	with contrast material (s)	1.20
70549	with contrast, followed by contrast	1.80

Codes 70546 and 70549 reflect the addition of the work relative value for 70544/70547 and ½ the work relative value for 70545/70548 (1.20+. 60 = 1.80).

Practice Expense Recommendations
The RUC recommended direct practice expense inputs for services performed in a non-facility setting. The RUC reduced the proposed time of 10 minutes to greet the patient to the standard time of three minutes. A series of modifications were also made to the supplies and equipment.

Magnetic Resonance Guidance Tab (TAB G)
Presenters: James P. Borgstede, MD and Robert Vogelzang, MD

Work Relative Value Recommendations
New code 76393 *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation* was created to describe MR guidance.

MR guidance is used to assist in the associated procedures (e.g., biopsy) for minimally invasive tissue sampling, fluid collection, as well as for guidance of injection of diagnostic substances. Currently, CPT does not contain an existing code that accurately describes MR guidance for needle placement; therefore the unlisted code 76499 *Unlisted diagnostic radiologic procedure* was reported.

The RUC recommends that the work relative value unit for 76393 *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation* be 1.50. The RUC agreed that 76393 is more work than 76360 *Computed tomography guidance for needle biopsy, radiological supervision and interpretation* (work RVU = 1.16) as this new service requires more physician time and has a higher level of intensity than 76360, as indicated in the specialty's survey data.

The RUC recommends a work relative value of 1.50 for code 76393.

Practice Expense Recommendations
The direct practice expense inputs for services performed in a non-facility setting reflect a RUC reduction of clinical staff time to 45 minutes, as well as, deletions in the medical supplies and overhead equipment categories.

Gait and Motion Analysis (TAB H)

Work Relative Value Recommendations
The RUC accepted the motion to refer the Gait and Motion Analysis codes back to the CPT Editorial Panel for reconsideration for further action.
The RUC recommended that these codes be carrier priced for 2001.

Practice Expense Recommendations
There are no direct practice expense recommendations.

Anesthesia Services (TAB I)
Presenter: Karl E. Becker, Jr., MD

Base Unit Recommendations
The RUC recommends the base units as presented by the American Society of Anesthesiology be interim values until the RUC has the opportunity to review these services and will forward to HCFA final recommendations when the RUC has the opportunity to do so.

Doctor Hoehn assigned RUC members William Gee, MD; Robert Zwolak, MD; William Rich, MD; Richard Haynes, MD, Richard Whitten, MD; and J. Leonard Lichtenfeld, MD to an Anesthesia Facilitation Committee. Doctor Hoehn specified that a conference call and meeting should be scheduled prior to the October, 2000 RUC meeting to review these recommendations for the anesthesia codes and echocardiography code and develop a report to the RUC for consideration.

Practice Expense Recommendations
The Specialty Society presented that these services are performed in the facility setting and; therefore, would not have any direct practice expense recommendations. The RUC; therefore, recommends no direct practice expense inputs for these codes.

Echocardiography (TAB J)
Presenters: Karl E. Becker, Jr., MD

Work Relative Value Recommendations
The RUC will consider this issue along with the other anesthesia services during the October 2000 RUC meeting and will forward any recommendations to HCFA at that time.

Practice Expense Recommendations
The Specialty Society presented that these services are performed in the facility setting and; therefore, would not have any direct practice expense recommendations. The RUC, therefore, recommends no direct practice expense inputs for these codes.

Intracardiac Echocardiography during Therapeutic/Diagnostic Intervention (TAB K)
Presenters: James Maloney, MD and David Schwartzman, MD

Work Relative Value Recommendations
New code 93662 *Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)* was created to describe intracardiac echocardiography which is an imaging tool used with interventional cardiology and electrophysiology applications. Using this technology, the physician is able to directly image cardiac structures and catheter position relative to cardiac anatomy during procedures.

The RUC compared new code 93662 to the reference service code 92978 *Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80). New code 93662 has a higher intra-service time than the reference code, in which the 55 minutes is dedicated to the imaging itself, which is performed during and following the primary procedure of placing the ultrasound probe. The intensity and complexity measures are greater for new code than the reference service code. The RUC agreed that the recommended work value of 2.80 was appropriate.

The RUC recommends a work relative value of 2.80.

Practice Expense Recommendations
There are no direct practice expense inputs, as this is an add-on code performed in a facility setting.

Peripheral Vascular Rehabilitation (TAB L)
Presenters: James Maloney, MD and Alan Hirsch, MD

Work Relative Value Recommendations
New code 93668 *Peripheral arterial disease vascular rehabilitation, per session* describes supervised, treadmill based programs of progressive limb exercise, with a subsequent transition to a home-based exercise prescription. This service is intended to treat patients with intermittent claudication, patients recovering from peripheral vascular surgeries or from peripheral angioplasty/stenting procedures. Currently, CPT does not contain an existing CPT code that accurately describes therapeutic vascular rehabilitation.

The RUC evaluated the survey results for new code 93668 *Peripheral arterial disease vascular rehabilitation, per session* and agreed that there was no physician work.

Practice Expense Recommendations
The RUC recommends that there are direct inputs for this service when performed in a non-facility setting. Specifically, the RUC recommends 20 minutes of RN/Exercise physiologist time for this service.

TAB M

Small Bowel Transplantation
The RUC requests that these services be carrier priced for one year to allow the specialty society to present survey data to the RUC in February 2001. The RUC will forward recommended relative values to HCFA for consideration for the 2002 Medicare Physician Payment Schedule.

Lymph Node Biopsy
Through the CPT Process (CPT/HCPAC Advisory Committee review), The CPT Editorial Panel will be implementing a CPT-5 recommendation to delete the "separate

procedure" designation from the code descriptor nomenclature and replace this designation with cross-references identifying specific services for which the code should not be separately reported. The two services listed below are the first to undergo this revision and have a corresponding cross-reference included. As the CPT Editorial Panel proceeds with this project, it is the intention that the RUC will review these changes to recommend to HCFA that they are indeed editorial or if the change (via inclusion or exclusion of certain codes in the cross-reference) is not editorial.

The RUC recommends that the replacement of "separate procedure" in the descriptor of codes 38500 and 38530 with the addition of new explanatory notes is editorial and not a change in the service. The RUC recommends no change in the current work relative values for these services.

Photon Beam Treatment Delivery
There is currently two existing codes to describe photon beam treatment delivery. These codes are carrier priced and the RUC requests that they, along with the two new codes, remain carrier-priced. In addition, the specialty society agreed that none of these codes require physician work.

Ocular Function Screening
The CPT Editorial Panel approved a new code for ocular function screening. The specialty society has informed the RUC that these services require no physician work and will not be covered by Medicare as they are screening services.

Subcommittee Reports
At this meeting, the RUC chose to place all Subcommittee reports on a "consent calendar" and extracted items for discussion. The Subcommittee chairs did not make formal presentations of their reports.

IX. Practice Expense Advisory Committee (PEAC) Report

Doctor Bill Moran presented the PEAC report. Doctor Moran explained that the PEAC has made significant progress during its meetings through its E/M workgroup and the establishment of standardized specialty supply and time packages. It is believed that the utilization of these types of building block approaches to the refinement of direct inputs will facilitate a more efficient means of providing HCFA with recommendations at subsequent PEAC meetings. Doctor Moran explained that the PEAC has asked each specialty to develop specific supply and time packages for groups of codes and informed the RUC that a pre-service clinical labor time workgroup had been established for the development of a pre-service time package to be presented at the next meeting. Doctor Moran informed the RUC that the PEAC had established a methodology of selecting codes for refinement and explained that specialties will review the direct inputs individually and the specialty recommendations will be assigned to several PEAC members who will lead the discussions for their assigned codes. The recommendations will be sent to PEAC members a month or more prior to the October meeting for their review.

The PEAC report was approved by the RUC without any modifications.

The RUC agreed that there are several standardization and packaging issues that still need to be addressed by the PEAC. Accordingly, the RUC recommends that HCFA considers the RUC recommendations on practice expense inputs "interim" until the PEAC considers and the RUC approves issues such as standardized clinical staff times.

These issues include:
1. Pre-service staff time packages
2. Level of clinical personnel (RN/LPN/MA/Tech) blend
3. Chaperon adjustments or other add on increments to the standardized E/M clinical staff time
4. Consent time for support personnel
5. Telephone call standards
6. Supply packing issues
7. Equipment packages
8. Equipment issues (special tables, defibrillators, etc)

After the PEAC approaches to such issues have been established, staff will return any interim code practice expense recommendations back to the RUC, with potential adjustments identified for reconsideration.

X. **Administrative Subcommittee Report**

The following issues were extracted from the Administrative Subcommittee report for discussion.

The Five-Year review consent calendars were amended as follows:

- Ms. Sherry Smith noted that code 43638 was added to consent calendar one in error. The Administrative Report should be changed to read, "The American Society of General Surgeons has withdrawn their comments related to code 34001 *Removal of artery clot*. This code will be added to the consent calendar "the RUC recommends no change in RVU's."
- Doctor Zwolak requested that a list of codes included in the Society of Vascular Surgeons comment letter to HCFA be added to the consent calendar "codes to be referred to the CPT Editorial Panel." Doctor Paul Rudolf agreed this would be appropriate. The RUC approved this addition to the codes referred to CPT.
- Doctor Nagel indicated that the American Academy of Orthopaedic Surgeons would like to extract CPT code 27218 from the consent calendar to retain the current value, as there was a calculation error. Doctor Nagel noted that the percent change was erroneously calculated at 9.93% by HCFA and should be 10%. Doctor Hoehn stated this would be forwarded to the appropriate Five-year review workgroup.

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

XI. **Research Subcommittee Report**

The following issues were extracted from the Research Subcommittee report for discussion.

SMS

Doctor Plummer asked for clarification regarding the SMS survey status on page three of the Research Subcommittee Report. Doctor Hoehn explained that the response rate of the survey has decreased while the cost of distributing the survey has increased. Doctor Hoehn indicated that the cost of producing and administrating the survey has significantly increased. The typographical errors in this paragraph will be corrected.

RUC Survey Instrument

Doctor McCaffree spoke against eliminating question three of the RUC survey instrument. The Research Subcommittee report had recommended that the rating of intensity of pre- intra- and post service periods shall be eliminated from the survey. Doctor Florin explained that this question was added to the survey instrument before the first Five-year review to analyze the levels of intensity in the various periods of service.

A spiked level of intensity in one time period may not indicate high intensity across the entire service. However, he argued that this information has not added much to the RUC's consideration in the past several years. Other RUC members spoke both in favor and against deletion of this question from the survey.

The RUC approved the following motion:
The Research Subcommittee should further review their recommendations to delete question three from the RUC survey instrument.

Doctor Zwolak extracted the following bullet for discussion, "The RUC will not survey the time for reference codes. Specialties should include time in the survey for reference services with references provided by the specialty society." Doctor Zwolak indicated there is some value in the survey process of requesting that respondents think about the time they spend performing the reference service code, rather than using the time on the reference service table as the definitive time for this service. He suggested that the RUC, instead consider requesting the historical RUC time to be included on the summary form.

The RUC made the following motion:

The Research Subcommittee should further review their recommendation to no longer survey physician time for reference services.

IWPUT

- Doctor Moorefield extracted bullet three as he objected to a consensus panel determination of IWPUT. The RUC could not validate these IWPUT recommendations.

- Doctor Lichtenfeld extracted all issues from the report, as he was concerned that IWPUT may not be valid methodology. The definition of IWPUT varies and there are no definitive IWPUT data available for intra-service work.

  There are many issues that need to be addressed first before utilizing this methodology.

- From the Chronology of RUC Actions, Doctor Hoehn quoted from the RUC's actions on September 27, 1997, "Intra-service intensity or IWPUT should be used only as a measure of relativity between codes or in families of codes. IWPUT is a complimentary measure and should not be used as the sole basis for ranking or the assignment of value to a service. The workgroup further observes that most formulas for the calculation of IWPUT use imputed values, there is no preferable formula."
- Doctor Florin explained that the American College of Surgeons (ACS) review identified negative IWPUT after pre/post service work was deducted from total work. The College then utilized Harvard/ Hsaio range of IWPUT to build back to total RVU's.
- Doctor Massanari stated that he was impressed with the rigor of the ACS study and that using a single expert panel within a family of codes may be acceptable. However, there are no cross-links available to assign IWPUTs across different families of codes.
- Doctor Mabry explained that the College attempted to apply a rationale approach to utilizing IWPUT and time to identify anomalies. He indicated that IWPUT is a measurement tool.
- Doctor McCaffree agreed that IWPUT is important information in reviewing RVU's, but it should not be set in stone.
- Doctor Lichtenfeld questioned whether the committee reviewed the study completed by Health Economics Research (HER). He expressed concern that the file of IWPUT provided by Jesse Levy of HCFA to ACS may be based on flawed methodology. He expressed concern regarding this file, specifically that it may be nonreproducible and contain old information.
- Doctor Sawchuck indicated that the report does not change current RUC rules. The RUC's rules regarding compelling evidence have not changed. A specialty society must still meet these requirements before a change in work RVU's may occur.
- The College repeated that their ultimate goal was to develop a better, more accurate way to measure work. RUC members responded that magnitude estimation has worked well. Others agreed that the building block/IWPUT methodology could be utilized, but not as the sole determinant of work relative values.

The RUC made the following motion:

The RUC reaffirms its action on intensity of September 27, 1997 and allows intra-service intensities and times to be developed by surveys or a consensus panel and be presented as relative intra-service work per unit time numbers. The use of this information in no way changes the current RUC policies regarding the use and interpretation of IWPUT information.

Doctor Lichtenfeld expressed concern regarding the first bullet on page 3, which states "The original Harvard preservice RVW formula with two levels of intensity; .0224 for evaluation and .0081 for scrub should be used." Doctors' Florin and Mabry explained that these intensities are historical and were obtained from the Hsaio study.

However, the RUC agreed there is not enough information to affirm that these levels of intensities are acceptable. RUC members agreed that intensities should not be set in stone and considered validated at this time.

The RUC approved the following motion:

To delete the bullet "The original Harvard preservice RVW formula with two levels of intensity; .0224 for evaluation and .0081 for scrub should be used" from the Research Subcommittee Report.

Concern was also expressed regarding the second bullet on page 3 of the Research Subcommittee report, which states, "Only the preservice time for the categories of evaluation and scrub/dress that are developed by surveys should be used in calculating the pre-service RVW's."

The RUC approved the following motion:

To delete the bullet "Only the preservice times for the categories of evaluation and scrub/dress that are developed by surveys should be used in calculating pre-service RVW's" from the Research Subcommittee Report.

Doctor Mabry asked for clarification regarding the pathway for ACS to approach the Five-Year review based on the RUC's actions. Doctor Hoehn explained that the RUC's actions did not preclude the College from using their approach and that the RUC will require compelling evidence to recommend a change in work values.

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

XII. Practice Expense Subcommittee Report

The following issues were extracted from the Practice Expense Subcommittee report for discussion.

Doctor McCaffree expressed concern regarding the third paragraph, which states, "If the data was not supplied by the specialties involved, the default office visit level would be 99213, the level HCFA's contractor used originally to calculate current HCFA physician time."

Sherry Smith explained that the practice expense has a huge task of reviewing missing level of E/M information. In instances where specialty societies have not provided the level of E/M service, instead of holding out indefinitely for the specialty to provide the necessary information, the RUC will add in a level 99213.

The Practice Expense Subcommittee report was approved without modification and is attached to these minutes.

XIII. **Health Care Professionals Advisory Committee Report**

The RUC Health Care Professionals Advisory Committee report was approved without modification and is attached to these minutes.

XIV. **Other Issues**

Doctor Hoehn requested that all specialty societies review their survey data and RUC recommendations for conciseness, accuracy and completeness prior to submission to the RUC. He also indicated that all specialty societies that have additional practice expense data should send the data to Sherry Smith one week after the conclusion of this meeting so that it may be forwarded to HCFA.

Multi-Specialty Points of Comparison (MPC)
Doctor Hoehn established the MPC workgroup which consists of the following RUC members:

Charles Koopmann, Jr., MD (Chair)
William Gee, MD
J. Leonard Lichtenfeld, MD
David McCaffree, MD
David Regan, MD
Robert Zwolak, MD
Stephen Bauer, MD (Advisor)
Jerilynn S. Kaibel, DC (HCPAC)

Doctor Hoehn stated that the workgroup should meet to begin discussion on Multi-Specialty Points of Comparison.

Doctor Hoehn expressed a heart felt thanks to all the RUC members for all their hard work at this meeting.

The meeting adjourned at 11:30 a.m. Sunday, April 30, 2000.

Facilitation Committee Report – Tab 25

Charles Koopmann, MD (Chair)
John Gage, MD
David McCaffree, MD
Sheldon Taubman, MD
Mark Lenet, DPM
Barbara Levy, MD
David Regan, MD

GG1 and GG2

The facilitation committee discussed and debated the pre-service time and agreed that it is reasonable.

The facilitation committee agreed that the intra-service time was appropriate.

The facilitation committee discussed the post-service time on the day of procedure and agreed that the discharge management was appropriate, however, the 99231 (hospital visit) time and work should be deducted from the total time and work as the patient is usually discharged on the same date. The committee agreed that the service should include one 99213 office visit, not the two visits as indicated in the survey.

The committee deducted the hospital visit and one office visit to arrive at a work relative value for 8.91 for GGI and 8.34 GG2.

GG3

The facilitation committee agreed that GG3 should represent average of 50% of GG1 (4.45) and GG2 (4.17). **The recommendation for GG3 is 4.31.**

GG4

The facilitation committee recommends that the survey work relative value median be approved for GG4 of 1.31.

The specialty society has also suggested that the physician pre-time should be deleted as it overlaps with the procedure code.

GG5

The facilitation committee recommends that the relativity of the original recommendations presented for GG4 and GG5 be maintained and therefore recommends 1.38 for GG5.

These services are performed in a facility setting. The facilitation committee recommends the E/M package for clinical staff time, supplies, and equipment for the 99213 visit included in the post-operative period for GG1 and GG2. GG3-GG5 require no practice expense inputs.

Facilitation Committee Report: 6461X F3
Chemodenervation of Muscles of the Trunk and the Limbs

The facilitation committee comprised of Doctors Hitzeman (chair), Florin, Hannenberg, Mayer, Rich, and Sigsbee discussed the recommended value for this service. The presenters stressed that this procedure is sufficiently more difficult than the reference service (RVU of 1.96). The service being reviewed is technically more complicated and the typical patient, which is either a stroke or cerabal palsy patient, involves more work. Also, this procedure involves injections of 4-8 muscles while the reference procedure involved injections to less than four muscles. The committee also looked a the family of chemodenervation codes and compared it to codes such as 67345 with a value of 2.96. Given the range RVUs in the family, the committee concluded that a value of 2.20 was valid and also concluded that the vignette may have understated the work involved and affected the survey results.

The facilitation committee recommends a work RVU of 2.20.

FACILIATION COMMITTEE
PERCUTANEOUS MANAGEMENT OF DIALYSIS GRAFT/FISTULA

The Facilitation Committee met on April 29, 2000 to discuss code *3686X Thrombectomy, percutaneous arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* which has a recommended work RVU of 6.85 which is the survey median work value.

The Committee identified that there are three services that will always be provided together; new code 3686X (Societies' recommended RVW of 6.85; 090 global), 36145 (RVW 2.01), and 75790 (RVW .54).

3686X	6.85
36145 (2.01 * .5)	
(50% reduction)	1.00
75790	1.84
	9.69

The Committee reviewed 36831 (RVW 8.00; 090 global) "Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft." If this service is reduced by 1.00 and 1.84, the resulting RVW is 5.16.

The Committee also reviewed 36860 (RVW 2.01; 000 global) "External cannula declotting; without balloon catheter" and 35473 (RVW 6.04; 000 global) "Transluminal balloon angioplasty, percutaneous; iliac" and determined that this 3686X was roughly in this range. The Societies' agreed to a value of 5.16, recognizing that it also incorporated a 090 global. **The Committee recommends a RVW of 5.16.**

Facilitation Committee #4 Report

Tab E - Magnetic Resonance Imaging Procedure
Tab F – Magnetic Resonance Angiography (Head & Neck)

April 29, 2000

The facilitation committee members were Doctors Joel Bradley (Chair), Richard Hayes, Alan Plummer, Paul Schnur, James Borgstede, Arliss Pollack, and Nelda Spyres. The facilitation committee discussed the typical patient services, and survey results in detail, for both tabs, and developed the following recommendations.

Tab E - Magnetic Resonance Imaging Procedure – T1 – T3
All three of these Magnetic Resonance Imaging Procedures are currently being coded with 70540. The CPT proposal was submitted to create a code structure consistent with the MRI brain and MRI spine codes, as well as parallel to codes for CT imaging.

T1
The facilitation committee agreed that the use of a contrasting agent, added more work to the service since its introduction. Considering the complexity of this base code, the facilitation committee recommends no change of the work value for the revised code 70540. RVW = 1.48
HCFA is currently using 36 minutes as the physician time for T1.

T2
The facilitation committee agreed that the RVW differential between other families of MRI codes, for with and without contrast was at least .30, (70551 and 70552, 72141 and 72142) and that this differential added to the base code RVW of 1.48 totaled the committee's recommended RVW of 1.78. Physician time is recommended at a total of 32 minutes.

T3
The facilitation committee agreed that the work differential between other families of MRI codes, for "without contrast material, followed by contrast material(s)", was at least .88, (70551 and 70553, 72141 and 72156) and that this differential added to the base code RVW of 1.48 totaled the committee's recommended RVW of 2.36. Physician time is recommended at a total 37 minutes.

Practice Expense Inputs
The facilitation committee recommends that T1, T2, and T3 be crosswalked to existing CPEP inputs for codes 70551, 70552, and 70553. These CPEP inputs follow this report.

Facilitation Committee #4 Report – Continued

Tab F – Magnetic Resonance Angiography (Head & Neck)
Currently all 6 types of Magnetic Resonance Angiography are being billed a 70541. This current code was exploded into 6 new codes by the CPT Editorial Panel. For increased work, intensity and complexity the modifier 22 is currently used with this code.

The facilitation committee recognized that approximately 40% of the scans would be combined (head and neck) and that 90% of brain scans would be without contrast and 10% with contrast. An estimated 60% of neck scans will be performed with contrast. Through a committee approved analysis by Doctor Haynes, it was termed that these codes now have 32% more work than previously reported. Since 1994 when the codes were first published by CPT, after the RUC recommended values, more services are performed with contrast, and more services are performed on both the head and neck. Services with contrast are performed more often, and no current code exists for the performance of these studies with contrast materials, which was not generally utilized for this procedure when the code was originally developed.

The facilitation committee decided that these codes should keep their proposed RVW's and physician time, as listed below:

PP1	RVW= 1.20	Physician Time = 25
PP2	RVW=1.20	Physician Time = 30
PP3	RVW=1.80	Physician Time = 31
PP4	RVW= 1.20	Physician Time = 25
PP5	RVW= 1.20	Physician Time = 40
PP56	RVW= 1.80	Physician Time = 40

RUC time associated with the currently billed code is; 5 minutes pre-service, 22 minutes intra-service, and 14 minutes post-service.

Practice Expense Inputs
The facilitation committee agreed to decrease clinical labor time for all codes in the intra service period, by deleting the obtaining of vital signs, and decreasing the greeting the patient time from 10 minutes to 3, where appropriate. Other practice expense inputs remain the same.

Facilitation Committee Report

Facilitation Committee Members
W. Benson Harer, MD (Chair)
John Gage, MD
Charles Koopmann, MD
David McCaffree, MD
David Regan, MD
Sheldon Taubman, MD
Sandra Reed, MD (Advisor)

Cryosurgical Ablation of the Prostate Tab 6

The Facilitation Committee recommends that the CPT Editorial Panel reconsider its action to create a separate code for ultrasonic guidance for interstitial cryosurgical probe placement, as the service is an inherent component of the cryosurgical ablation of the prostate, code 5585X. The Committee agreed that the global work relative value for the service, 5585X should be 19.92 with 1.92 representing the ultrasonic guidance component. The Committee arrived at these recommendations based on the following assumptions:

A suggested IWPUT of .071 was applied to the intraservice time	200 min x.071 = 14.2
A preservice RVU	= .90
Same day post time RVU	= 1.51
Discharge day RVU	= 1.28
Office Visit RVU (3, 99213)	= 2.01
Total work RVU	19.90

The ultrasound guidance component was felt to be most similar to the original RUC recommendation of 1.92 for code 76965 *Ultrasonic guidance for interstitial radioelement application*.

The Facilitation Committee also recommends that the preservice clinical staff time be reduced to from 89 minutes to 45 minutes (for RN/LPN). The Committee recommends approval of all other practice expense inputs for this service as presented.

Reversal of Sling Operation Tab 7
The Facilitation Committee recommends that code 572XX *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)* is similar to work as code 51840 *Anterior vesicourethreopexy, or urethropexy (Marshall-Marchetti-Krantz, Burch); simple* and accordingly recommends a work relative value of 10.71. The Harvard intraservice time for code 51840 is 74 minutes, which is comparable to the 70 minutes of intraservice time for new code 572XX.

The RUC had approved the practice expense inputs for 572XX. However, in response to a question raised, the Facilitation Committee recommends that the syringe with water be modified to be supply code 91407 Syringe, 10cc – 12cc

The Facilitation Committee met and discussed the relative work value for code 3314X. The Committtee first determined what methodology it should utilize to arrive at a work value. Two recognized possibilities were the 50% rule and the comparison against other services with known work values. The committee discussed both methodologies and decided that it would focus on the services with known RVU's.

The Committee looked at the descriptor of the service and discussed how the service would be provided. It became evident that the service would usually be unplanned rather than planned. Usually, the surgeon would plan to replace multiple vessels; however once the physician began the procedure, it would be determined that a vessel could not be replaced. At this time, the decision would be made to perform TMR instead.

It was recognized that the only way to make the determination that the vessel was unsuitable for replacement would be after dissection and evaluation, and that such work would not be covered under the vessel graft service. Also, it was recognized that preparing the TMR equipment for surgical use was neither covered in the graft service or the TMR service.

The Committee reviewed the differential RVU's from the CABG (vein) codes for:
33510 – 25.00
33512 – 27.40
33153 - 29.67
33514 – 31.95

The average differential between respective codes is 2.28 (i.e, the incremental work of dissection and replacement of a single vessel). This recognizes the incremental value of dissecting down to the vessel. The Committee felt that, for dissecting down to a vessel and then evaluating that the vessel could not be replaced, half of 2.28 (1.14) was an appropriate value.

The Committee was advised that it takes approximately 20 minutes to prepare the TMR equipment for surgical use, a time component which was not considered by the surveyors. The value of this 20 minutes waiting for the equipment with a patient with an open chest and on bypass, was deemed to be similar to a little less than a half hour of critical care, and attributed 1.4 RVW's. The Committee deemed that the 30 minutes intra service time was equal to a half hour of critical care (1.8 RVW's) plus 0.5 RVW's in using the laser for a total of 2.3 RVW's.

A secondary comparison was made for the 30 minutes of intra service time. The Committee used as a reference service code 33530 which has a ZZZ global period with 156 minutes intra service Harvard time and a specialty recommended 12 RVW's when originally presented to the RUC. This provides an IWPUT of 0.077 and when multiplied by 30 minutes intraservice time, provided 2.31 RVW's.

1.14 + 1.4 + 2.3 = 4.84 RVW's

Therefore, the Facilitation Committee recommends a work relative value of 4.84.

Facilitation Committee Report

Facilitation Committee Members:
Joel Bradley, MD (Chair)
Richard Haynes, MD
Trexler Topping, MD
Paul Schnur, MD
John Derr, MD
Sheldon Taubman, MD

Work RVU for 19103

The Facilitation Committee discussed the relative work value for new code 19103. The Committee agreed that the physician work and intensity and complexity factors are greater for new code 19103 than the reference service code. Specifically, the Committee discussed the complexity involved in using the biopsy device. This involves complex manipulation of the device and requires additional physician time. Given this additional complexity, the Committee recommends the median survey value of 2.37. Additionally, this procedure is currently being reported using CPT code 19101 (work RVU of 3.18 with 30 minutes of intra-service time). Therefore, the Facilitation Committee feels that the recommended work value of 2.37 is appropriate for this procedure.

Practice Expense Inputs for 19102 and 19103

The Facilitation Committee did not make a recommendation on supplies and equipment due to pending HCFA review at this meeting.

The Facilitation Committee did review the clinical staff time for both, new CPT codes 19102 and 19103. The Committee felt that an appropriate method for establishing clinical staff time for these codes would be to crosswalk the existing inputs from code 76942. The Committee felt that the clinical staff activities were comparable in time (102 minutes) and also since both codes have 30 minutes physician intra-service time. The Facilitation Committee refined these clinical inputs further as reflected in the attachment and recommends total clinical staff time of 100 minutes as follows:

CPT Codes: 19101X1
19101X2

TYPE OF SERVICE: Surgical Procedures
000 Global Period
SITE OF SERVICE: In-OFFICE

Clinical Services	**Minutes**	**Staff Type – Circle**	
Pre-Service Period			
Start: Following visit when decision for surgery or procedure made		**RN, LPN, MA, Other**	
Complete pre-service diagnostic & referral forms		RN, LPN, MA, Other	
Coordinate pre-surgery services		RN, LPN, MA, Other	
Office visit before surgery/procedure Review test and exam results		RN, LPN, MA, Other	
Provide pre-service education/obtain consent		RN, LPN, MA, Other	
Follow-up phone calls & prescriptions		RN, LPN, MA, Other	
Other Clinical Activity (please specify)		RN, LPN, MA, Other	
End: When patient enters office for surgery/procedure			
Service Period			
Start: When patient enters office for surgery/procedure			
Pre-service services			
Review charts	6	RN, LPN, MA, Other	**RT(M)**
Greet patient and provide gowning	2	RN, LPN, MA, Other	**RT(M)**
Obtain vital signs	4	RN, LPN, MA, Other	**RT(M)**
Provide pre-service education/obtain consent	12	RN, LPN, MA, Other	**RT(M)**
Prepare room, equipment, supplies	8	RN, LPN, MA, Other	**RT(M)**
Prepare and position patient/ monitor patient/ set up IV	5	RN, LPN, MA, Other	**RT(M)**
Sedate/apply anesthesia	2	RN, LPN, MA, Other	**RT(M)**
Intra-service Assist physician in performing procedure	27	RN, LPN, MA, Other	**RT(M)**
Monitor pt. following service/check tubes, monitors, drains	9	RN, LPN, MA, Other	**RT(M)**
Clean room/equipment by physician staff	9	RN, LPN, MA, Other	**RT(M)**
Complete diagnostic forms, lab & X-ray requisitions	4	RN, LPN, MA, Other	**RT(M)**
Review/read X-ray, lab, and pathology reports	5	RN, LPN, MA, Other	**RT(M)**
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	4	RN, LPN, MA, Other	**RT(M)**
Other Clinical Activity (please specify)		RN, LPN, MA, Other	
End: Patient leaves office			

Facilitation Committee Report – Tab 25

Charles Koopmann, MD (Chair)
John Gage, MD
David McCaffree, MD
Sheldon Taubman, MD
Mark Lenet, DPM
Barbara Levy, MD
David Regan, MD

GG1 and GG2

The facilitation committee discussed and debated the pre-service time and agreed that it is reasonable.

The facilitation committee agreed that the intra-service time was appropriate.

The facilitation committee discussed the post-service time on the day of procedure and agreed that the discharge management was appropriate, however, the 99231 (hospital visit) time and work should be deducted from the total time and work as the patient is usually discharged on the same date. The committee agreed that the service should include one 99213 office visit, not the two visits as indicated in the survey.

The committee deducted the hospital visit and one office visit to arrive at a work relative value for 8.91 for GGI and 8.34 GG2.

GG3

The facilitation committee agreed that GG3 should represent average of 50% of GG1 (4.45) and GG2 (4.17). **The recommendation for GG3 is 4.31.**

GG4

The facilitation committee recommends that the survey work relative value median be approved for GG4 of 1.31.

The specialty society has also suggested that the physician pre-time should be deleted as it overlaps with the procedure code.

GG5

The facilitation committee recommends that the relativity of the original recommendations presented for GG4 and GG5 be maintained and therefore recommends 1.38 for GG5.

These services are performed in a facility setting. The facilitation committee recommends the E/M package for clinical staff time, supplies, and equipment for the 99213 visit included in the post-operative period for GG1 and GG2. GG3-GG5 require no practice expense inputs.

Facilitation Committee Report for 6225X (J1)
April 29, 2000

The facilitation committee members gathered during lunch were Doctors Alexander Hannenberg (Chair), Robert Florin, Trexler Topping, Gregory Przybylski, James Anthony, Frederick Boop, and Boyd Buser. The facilitation committee discussed the typical patient service in detail and developed the following recommendations.

Members of the specialty society explained that the physician work involved reading the setting of a CSF shunt valve implanted beneath the scalp, by personally performing patient positioning and an x-ray. To insure exact adjustment of the shunt valve, the physician performs specific patient positioning and x-rays before and after adjustment of the valve. The radiological services are not separately reported.

Intra-service work involves the reprogramming of the CSF shunt valve by using a hand held electronic transmitter, as well as positioning and x-raying the patient in order to insure the valve has been set correctly. Society members explained that the patient is at risk of sudden death and the importance of a correct valve setting.

Intra-service time was adjusted from 15 minutes to 20 minutes to reflect the work involved for patient positioning and x-ray time before and after reprogramming of shunt, to insure correct valve setting. Pre-service physician time was adjusted to 10 minutes from 15 minutes, with the understanding that the reference code has similar physician work involved.

Post-service time remains at 10 minutes for dictation, documentation, phone calls, and discussion with family.

RVW Recommendation and Rationale
The facilitation committee came to a consensus that code 6225X (J1) is most closely related to reference code of 93735 instead of 93738 and because of this change, and from a detailed explanation of the physician work, the committee recommends code 6225X (J1) to have a **RVW = 0.74,** rather than the specialty society's initial RVW of 0.92. The long descriptor of the new reference code is listed below:

> Electronic analysis of single 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); with reprogramming

The pre, intra, and post service times of this reference service code closely match those of J1, as does the complexity of the parameters involved.

Practice Expense Recommendation and Rationale
The facilitation committee came to the agreement on practice expense inputs that attached to this report. The facilitation committee increased the pre service time by 7 minutes of clinical labor expense, and kept its standard office visit supplies and equipment.

FACILITATION COMMITTEE
ENDOVASCULAR GRAFTS (TAB 26)

CPT Codes	Original Global	Original Specialty Society RVW	Recommended Global	Recommended RVW
3517X1	090	20.75	**090**	**20.75**
3517X2	090	23.00	**090**	**23.00**
3517X4	090	23.00	**090**	**23.00**
3517X6	090	8.95	**ZZZ**	**4.13**
3517X7	090	9.55	**000**	**6.75**
3517X9	ZZZ	4.80	**ZZZ**	**4.80**
3517X10	090	14.25	**000**	**9.75**
3517X12	090	12.00	**090**	**12.00**
3517X13	ZZZ	4.13	**ZZZ**	**4.13**
3517X14	090	32.59	**090**	**32.59**
3517X15	090	36.46	**090**	**35.34**
3517X16	090	37.10	**090**	**35.34**
7595X1	XXX	4.50	**XXX**	**4.00**
7595X2	XXX	1.36	**XXX**	**1.36**

The Committee considered whether or not the Societies' description of the coding for services adjunctive to the respective presented services was consistent with current accepted coding practices. The Committee was advised that such description was correct. However, it was suggested that the **CPT introductory notes to "Endovascular Repair of Abdominal Aortic Aneurysm" be revised to better clarify the appropriate coding of relevant multiple services provided in a single session.**

The Committee considered the format of the survey instruments utilized in the presentation. It was clarified that in each case, the surveys received CPT code, global period designation, CPT descriptor, vignette, and descriptions of pre-service work, intra-service work inclusions, post-work, and services that could be separately billable and therefore not included in the surveyed service. The clinical description of pre-intra-post-service work was not provided to the surveyees. There was discussion of possible effects of the statement of the excluded services. It was the consensus of the committee that given the intricacies of the accepted coding for these types of services, stimulating the list of excluded services better ensured that the work of the respective presented service was appropriately surveyed.

3517X7
After much discussion, the Committee deemed that this service was very similar in work to 33970 (RVW 6.75; global 000) "Insertion of intra-aortic balloon assist device through the femoral artery, open approach" and that the 090 global designation was inappropriate for 3517X7. **With reduction to a 000 global the committee recommends the work value of 6.75.**

3517X2
When performing this service, there is a need to access the femoral artery (3517X7) which is the open femoral artery exposure. Imaging 7595X1 constitutes the imaging of all the services (e.g., ballooning, stenting) and is only reported time.

The current recommended work value for code 3517X2 is 23.00 The preservice time (135 minutes) is relatively higher than the reference service code 35102 (95 minutes) as you have to review CT scans and aortograms and measure the diameter and length of the graft needed and order the graft, which is included in the new code and is not captured with a separate E/M code or other service code.

The Committee agreed that 35102 (RVW 30.76; global 090) was a reasonable reference code for this service. The Committee discussed the service times for reference service code 35102 (180 minutes) and noted they are higher than compared to the new code 3517X2 (150 minutes). The Committee recognized that the societies recommended the 25th percentile RVW of 23.00 based upon two validation methodologies. **Therefore the Committee felt that the recommended work value of 23.00 was appropriate.**

3517X4

The Societies presented the 25th percentile RVW of 23.00. The Committee was comfortable that this service was similar in work to 3517X2. **The Committee recommends a work value of 23.00.**

3517X1

The Committee reviewed codes 35102 (RVW 30.76; global 090) and 35081 (RVW 28.01; global 090) and determined a difference of 2.75 RVWs for involvement of iliac vessels. This was compared to the differential of 2.25 between 3517X1 and 3517X2. **The Committee recommends a work value of 20.75.**

3517X9

The Committee reviewed code 35661 (RVW 13.81; global 090) and reduced this value by 6.75 RVW for one groin and half of 6.75 (3.38) for the second groin to arrive at a work value of 3.68. Given the rough calculations, the committee felt comfortable with the originally recommended value of 4.80.

The question was raised regarding what would be done if 3517X7 and 3517X9 were performed without introduction of a device. The Committee agreed that there should be a CPT note that indicates that if these are performed without the delivery of an endovascular prosthesis, there should be an appropriate coding edit (perhaps indicating 35661). The presenters agreed that it would be appropriate to ask for such an editorial change.

The Committee recommends a work value of 4.80. The Committee recommends that CPT review appropriate edits when 3517X7 and 3517X9 are performed without introduction of an endovascular prosthesis.

3517X10

The Committee compared code 49010 (RVW 12.28; global 090) "Exploration, retroperitoneal area with or without biopsy(s)" and felt that this service was roughly comparable to the work of 3517X10. However, the committee felt that 3517X10 would be better designated as a 000 global and decided to delete the after service care resulting in an RVW of 9.75. **The Committee recommends a RVW of 9.75. The Committee also recommends a 000 global**.

3517X6

The Committee determined that this code would not be independently performed. **Therefore, the Committee recommends that it be designated a ZZZ global.** The Committee reviewed code 37206 (RVW 4.13; global ZZZ) "Transcatheter placement of an intravascular stent(s), (non-

coronary vessel), percutaneous; each additional vessel." **The Committee recommends a work value of 4.13.**

3517X12

Based upon all services reviewed up to this point, the Committee recommends an RVW of 12.00.

3517X13

The Committee identified that this would only be performed with 3517X12 and felt the recommended work value of 4.13 was appropriate.

3517X14

The Committee compared 35081(RVW 28.01) and 35082 (RVW 36.35) and felt that the work of 3517X14 was roughly in the mid-range of these two services. **The Committee recommends a work relative value of 32.59.**

3517X15

The Committee compared reference service codes 35081 (RVW 28.01) and 35102 (RVW 30.76) and calculated a difference of 2.75 RVW's between these two codes. When this was added to 3517X4, the resulting RVW was 35.34. **The Committee recommends a work value of 35.34.**

3517X16

The Committee determined that the work of 3517X16 was equivalent to 3517X15. **Therefore, the Committee recommends a work value of 35.34.**

7595X1

The Committee was concerned that the low number of survey responses from Interventional Radiologists might have inappropriately skewed the survey results. Therefore, the Committee felt that any value approved should be an interim value until the Interventional Radiologists conduct another survey. Based upon this concern, the Committee decided to take the mid-point value between the median of 3.50 RVW and the Society's recommended work value of 4.50.
The Committee recommends an interim work value of 4.00.

7595X2

The Committee noted that the Society's presented a recommendation of 1.36 RVW which was less than their 25th percentile. **The Committee recommends a work value of 1.36.**

43219 (2.80) – 43200 (1.59) = 1.21
43226 (2.34) - 43200 (1.59) = 0.75
1.96

KK1 = 44388 + 1.96 = 4.78
KK2 = 45300 + 1.96 = 2.66
KK3 = 45330 + 1.96 = 2.92
KK4 = 45378 + 1.96 = 5.66

Cutaneous Electrogastrography Provocative Testing (TAB 31)

The Facilitation Committee recommends that these services be carrier-priced as currently very few physicians perform these services.

Photodynamic Therapy (TAB A)

The Facilitation Committee recommends that the HCFA established values are reasonable and that the RUC recommends them to be proposed as interim RUC recommendations.

XX1 96570 Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus) 1.10

XX2 96571 each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus). .55

Medical Nutrition Therapy (TAB B)

The societies presenting have withdrawn these recommendations. The American Dietetic Association will ask the CPT Editorial Panel to reconsider the nomenclature. Any resulting codes and descriptors will be forwarded to the HCPAC for evaluation.

The Pre-facilitation Committee also agrees that a subcommittee of the RUC should review the procedures to determine which services should be forwarded to the HCPAC rather than the RUC as CPT approves new codes predominately performed by non-MD/DO health care professionals.

Pre-Facilitation Committee Report

A pre-facilitation committee (Doctors Richard Whitten (Chair), Alexander Hannenberg, Barbara Levy, David Massanari, David Regan, Eugene Wiener, and Don Williamson, OD) met Friday, April 28 at the request of the American Dietetic Association, American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy to review the issues in Tab 29, 30, 31, A, and B of your agenda book. The pre-facilitation committee recommends the following action:

GI Endoscopy Procedures (Tab 29)

The pre-facilitation recommends the following interim work RVUs for GI Endoscopy:

	43200	1.59	
	43202	1.89	
Y1	**4320X1**	**4.09**	
Y2	**4320X2**	**4.71**	
	43235	2.39	
			2.50 increment (ultasound)
	43259	4.89	
Y3	**4325X1**	**5.51**	
Y4	**4325X2**	**7.39**	
	45330	.96	
Y5	**453X1**	**3.46**	
Y6	**453X2**	**4.08**	

The rationale for each is as follows:

Y1 = 1.59 (43200) + 2.50 (ultrasound increment)* = 4.09

Y2 = Y1 (4.09) + .62 (biopsy increment)** = 4.71

Y3 = 43259 (4.89) + .62 (biopsy increment)** = 5.51

Y4 = The committee recommends that this service is equivalent to code 43262 *Endoscopic retrograde cholangio-pancreatography (ERCP); with sphincterotomy/papillotomy* (7.39)

Y5 = 45330 (.96) + 2.50 (ultrasound increment)*= 3.46

Y6 = Y5 + .62 (biopsy increment)**

*ultrasound increment = 43259 (4.89) – 43235 (2.39) = 2.50
**biopsy increment = 19291 (0.63) and the increment between 31629 (3.37) and 31522 (2.78)

Endoscopic Enternal Stenting (Tab 30)

The pre-facilitation committee recommends the following interim work RVUs for Endoscopic Enternal Stenting:

KK1	4439X	4.78
KK2	4530X	2.66
KK3	453XX	2.92
KK4	4538X	5.66

These values represent the current relative value for the base code plus an increment of 1.96 for the "transendoscopic stent placement (includes predilation)" arrived at as follows:

43219 (2.80) – 43200 (1.59) = 1.21
43226 (2.34) - 43200 (1.59) = 0.75
1.96

KK1 = 44388 + 1.96 = 4.78
KK2 = 45300 + 1.96 = 2.66
KK3 = 45330 + 1.96 = 2.92
KK4 = 45378 + 1.96 = 5.66

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The Facilitation Committee recommends that these services be carrier-priced as currently very few physicians perform these services.

Photodynamic Therapy (TAB A)

The Facilitation Committee recommends that the HCFA established values are reasonable and that the RUC recommends them to be proposed as interim RUC recommendations.

XX1 96570 Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus) 1.10

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Medical Nutrition Therapy (TAB B)

The societies presenting have withdrawn these recommendations. The American Dietetic Association will ask the CPT Editorial Panel to reconsider the nomenclature. Any resulting codes and descriptors will be forwarded to the HCPAC for evaluation.

The Pre-facilitation Committee also agrees that a subcommittee of the RUC should review the procedures to determine which services should be forwarded to the HCPAC rather than the RUC as CPT approves new codes predominately performed by non-MD/DO health care professionals.

E/M 99213 (RVW = 0.67)

1. Patient's family calls office reporting headache, nausea, lethargy
2. CT Scan and shunt series obtained
3. History and physical done and shunt malfunction determination is made. In this instance decision is determined that reprogramming is needed.

6225X Reprogramming of shunt valve

Pre-service (10 minutes physician work)
1. Skull x-ray obtained tangential to skull with physician positioning
2. Review and interpretation of current valve setting (completely separate from the skull based radiography interpretation)

Intra-service (20 minutes physician work)
1. Changing the setting
2. Skull x-ray obtained again to determine if appropriate valve setting was obtained
3. Interpretation of setting from x-ray
4. Possible subsequent reprogramming of valve if not appropriately targetted
5. Reprogramming complete

Post-Service (10 minutes physician work)
1. Discuss the necessary change with the family
2. Dictate letter for chart and referring physician
3. Document procedure note

E/M 99213 Practice Expense (36 minutes for the standard PEAC package vs. 60 minutes determined as typical through consensus panel)

1. Phone call	10 minutes
2. Pull chart/x-ray	5 minutes
3. Call physician	5 minutes
4. Pre-certification office visit/ ct & x-rays	15 minutes
5. Schedule studies/visit	10 minutes
6. Call family with times	5 minutes
7. Office intake/vitals	5 minutes
8. Dictate encounter notes`	5 minutes

6225X Practice Expense
TOTAL Time 35 minutes

Pre-service

1. Schedule skull x-ray	2 minutes
2. Nurse escorts/monitors pt for x-ray(s)	20 minutes

Intra-Service

1. Set-up computer	3 minutes
2. Assist w/ reprogramming	3 minutes
3. Take patient back to exam room	2 minutes

Post-service

1. Call family w/ follow-up	5 additional minutes beyond 99213

CPT Code: 70551

Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material

Global Period XXX

CPEP ***C 6*** ***Physician Time:*** 36 ***Minutes*** ***HCFA Office Visits:*** 0 ***CPT Code*** 70551

Clinical Labor

Code 70551

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MRI Technician	0	96	0	0		0				
RN	0	21	0	0		0				

Medical Supplies

Code 70551

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
drape, sheet	0	0	0	0	0	0		11106	2 item	0 item
film, 14x17	0	0	0	0	0	0		73402	10 sheet	0 sheet
gloves, non-sterile	0	0	0	0	0	0		11302	1 pair	0 pair
patient gown, disposable	0	0	0	0	0	0		11107	1 item	0 item

Overhead Equipment

Code 70551

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
crash cart , no defibrilator							E91002		0	0

Procdure Specific Equipment

Code 70551

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MR Room							E51058			

CPT Code: 70552

Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)

Global Period XXX

CPEP ***C 6*** ***Physician Time:*** 43 ***Minutes*** ***HCFA Office Visits:*** 0 ***CPT Code*** 70552

Clinical Labor

Code 70552

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MRI Technician	0	96	0	0		0				
RN	0	21	0	0		0				

Medical Supplies

Code 70552

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
angiocatheter 20 to 25g	0	0	0	0	0	0		91106	1 item	0 item
contrast (1% methylene blue)	0	0	0	0	0	0		93110	10 ml	0 ml
drape, sheet	0	0	0	0	0	0		11106	2 item	0 item
film, 14x17	0	0	0	0	0	0		73402	10 sheet	0 sheet
gloves, non-sterile	0	0	0	0	0	0		11302	1 pair	0 pair
iv infusion set	0	0	0	0	0	0		91110	1 set	0 set
patient gown, disposable	0	0	0	0	0	0		11107	1 item	0 item
syringe med rad 150 cc cartridge	0	0	0	0	0	0		73615	1 item	0 item

Overhead Equipment

Code 70552

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
crash cart , no defibrilator							E91002		0	0

Procdure Specific Equipment

Code 70552

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MR Room							E51058			

CPT Code: 70553

Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences

Global Period XXX

CPEP ***C 6*** ***Physician Time:*** 56 ***Minutes*** ***HCFA Office Visits:*** 0 ***CPT Code*** 70553

Clinical Labor

Code 70553

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MRI Technician	0	116	0	0		0				
RN	0	21	0	0		0				

Medical Supplies

Code 70553

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
angiocatheter 20 to 25g	0	0	0	0	0	0		91106	1 item	0 item
contrast (1% methylene blue)	0	0	0	0	0	0		93110	10 ml	0 ml
drape, sheet	0	0	0	0	0	0		11106	2 item	0 item
film, 14x17	0	0	0	0	0	0		73402	14 sheet	0 sheet
gloves, non-sterile	0	0	0	0	0	0		11302	1 pair	0 pair
iv infusion set	0	0	0	0	0	0		91110	1 set	0 set
patient gown, disposable	0	0	0	0	0	0		11107	1 item	0 item
syringe med rad 150 cc cartridge	0	0	0	0	0	0		73615	1 item	0 item

Overhead Equipment

Code 70553

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
crash cart , no defibrilator							E91002		0	0

Procdure Specific Equipment

Code 70553

	Pre In Office	Intra In Office	Post In Office	Pre Out Office	Intra Out Office	Post Out Office	Equipment Code	Supply Item Code	Qty of Supply units in office	Qty of Supply units out office
MR Room							E51058			

AMA/Specialty RVS Update Committee
Administrative Subcommittee
April 27, 2000

The following members of the Administrative Subcommittee met on Thursday, April 27: Alexander Hannenberg, MD (Chair), Lee Eisenberg, MD, Charles Koopmann, MD, David Regan, MD, William Rich, MD, Paul Schnur, MD, Richard Whitten, MD. The Subcommittee discussed the Five-Year Review and the development of a conflict of interest policy.

Five-Year Review

The Subcommittee heard an update from Doctor Paul Rudolf regarding HCFA's progress in identifying services for the Five-Year review. HCFA continues to review various sources of data to validate the physician time data currently utilized. This project is expected to be ongoing and it is unlikely that the RUC would receive an additional referral of codes in 2000. Members of the Administrative Subcommittee expressed concern that specialty societies be given the same opportunity as HCFA to identify additional codes on a "rolling" basis. Doctor Rudolf suggested that this opportunity may exist and the RUC may wish to consider a mechanism for this ongoing review after completion of this Five-Year review.

The Subcommittee reviewed the consent calendars as presented in the RUC agenda materials with the following modifications:

- The American Society of General Surgeons has withdrawn their comments related to code 34001 *Removal of artery clot*. This code will be added to the consent calendar "The RUC recommends no change in work RVU's."

- The American Society of Transplant Surgeons has requested that code 47134 *Partial removal, donor liver* be added to the consent calendar "Issues to be referred to the CPT Editorial Panel for review."

- The Administrative Subcommittee recommends that CPT code 90911 *Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry* be reviewed by a Five-Year workgroup. HCFA received this comment from an organization external to the RUC process and no specialty society expressed an interest in presenting a recommendation for this service. The RUC had previously reviewed this issue and HCFA did not accept the RUC recommendation. The Subcommittee suggested that the workgroup be given this information, along with any other supporting documentation that the specialties that perform these services wish to provide.

- The American Academy of Orthopaedic Surgeons has requested that CPT code 27218 *Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)* be pulled from the consent calendar. The RUC agreed that the AAOS may present data at the August workgroups on this code.

- The Society of Vascular Surgery requested that the list of codes on page four of their comment letter to HCFA be included on the consent calendar "Issues to be referred to the CPT Editorial Panel for review." The RUC agreed that this was appropriate.

The Administrative Subcommittee recommends RUC review and adoption of the following consent calendars:

1. **RUC recommends no change in work RVU's (128 codes)**

2. **RUC recommends the proposed decreased work RVU (2 codes)**

3. **Codes to be referred to the CPT Editorial Panel (39 codes)**

All other codes are either identified on a Five-Year Status Table for either the RUC (398 codes) or HCPAC (12 codes).

In addition to these codes, the American College of Surgeons will present 322 codes and the American Society of Anesthesiologists will present their study. A list of the workgroups (as revised) and their specific code assignments were included as handouts at this meeting.

Conflict of Interest Policy

The Administrative Subcommittee reviewed the RUC's request to develop a Conflict of Interest Policy. The Subcommittee notes that the RUC's Structure and Function contains such a statement and recommends that it be amended as follows:

> No RUC or other Committee or Subcommittee representative will vote or participate in any deliberation on a specific issue in the event the representative has a financial interest in the outcome of the vote or deliberation other than the representative in the course of their practice performing the procedure or service at issue. Every RUC or other Committee or Subcommittee representative shall disclose his or her potential interest prior to any vote or deliberation and shall not vote or participate in the deliberation. **Any individual who is presenting or discussing relative value recommendations before the RUC shall disclose his or her potential interest prior to any presentations.**

The Administrative Subcommittee also agreed that the RUC needed a mechanism to enforce this policy and **recommends that a disclosure document be prepared by AMA counsel.**

Other Issues

The Administrative Subcommittee also discussed the need for more time to review the large amount of materials presented for the April meeting. Staff explained that the RUC is provided less time as the time period between the February CPT meeting and the April RUC meeting. Specialty societies require time to conduct the surveys and collate their data. It was suggested that the RUC might wish to request that HCFA move the deadline for RUC recommendations from May 31 to late June. The RUC could then meet in late May or early June to provide the specialties with additional time and RUC members a few more weeks to review the materials.

AMA/Specialty Society RVS Update Committee
Five-Year Review of the RBRVS

Workgroups

Workgroup 1 – Vascular Surgery

James Hayes, MD (Chair)
Robert Florin, MD
David Massanari, MD
James Blankenship, MD
Trexler Topping, MD

Workgroup 2 – General Surgery

James Moorefield,MD (Chair)
William Gee, MD
David Hitzeman, MD
William Rich, MD
Peter Sawchuk, MD

Workgroup 3 – Thoracic Surgery

Don Williamson, OD (Chair)
Barbara Levy, MD
John Derr, MD
Norman Cohen, MD
Richard Tuck, MD
*David Regan, MD**

Workgroup 4 – Anesthesiology

Alan Plummer, MD (Chair)
David McCaffree, MD
Charles Koopmann, MD
Robert Zwolak, MD
Gregory Przybylski, MD

Workgroup 5 – Ortho, Ob/Gyne, Urology And Ophthalmology

Alexander Hannenberg, MD (Chair)
Lee Eisenberg, MD
J. Leonard Lichtenfeld, MD
John Mayer, MD
Clay Molstad, MD
*Chester Schmidt, MD**

Workgroup 6 – All Other Issues

Richard Whitten, MD (Chair)
Richard Haynes, MD
Joel Bradley, MD
Sheldon Taubman, MD
James Regan, MD

Workgroup Meeting, August 24-27, 2000, Chicago, Illinois:

Thursday, August 24, 1:00 pm – Friday, August 25, 6:00 pm	Workgroup 2,4,6
Saturday, August 26, 8:00 am – Sunday, August 27, noon	Workgroup 1,3,5

* Will not be in attendance at August workgroup meetings

AMA/Specialty RVS Update Committee
Practice Expense Advisory Committee

April 25-26, 2000

Chicago, Illinois

Bill Moran, MD (Chair)
James Anthony, MD
Timothy Bateman, MD*
Michael Berman, MD
James Borgstede, MD
Joel F. Bradley, MD
Ann C. Cea, MD, FACR
Neal Cohen, MD
Anthony N. DeMaria, MD
Thomas A. Felger, MD
Robert H. Haralson, MD
Rebecca Johnson, MD
Ronald L. Kaufman, MD, MBA
Gregory Kwasny, MD
Candia Baker Laughlin, MS, RN
Dwight Lee, MD
Marc Lenet, DPM*
Alex G. Little, MD
Ron Nelson, PA-C
Frank Opelka, MD
Tye Ouzounian, MD
Dighton C. Packard, MD
Fredrica Smith, MD
Greg Przybylski, MD
James Regan, MD
Jeffrey Resnick, MD
Ronald Shellow, MD
Daniel Mark Siegel, MD, MS
Susan Spires, MD
Robert Stomel, DO
Charles H. Weissman, MD
Don Williamson, OD
*Wednesday Only

Call To Order and Introduction of New Members

Doctor Moran called the PEAC meeting to order and welcomed members and introduced the following new PEAC members: Doctors James Anthony and Greg Przybylski.

E/M Workgroup Recommendations

Doctor Templeton introduced the workgroup's recommendations and report for the direct inputs for 15 E/M codes via phone. The approved Workgroup report follows this PEAC report. The workgroup based its recommendations using the 1997 E/M guidelines as will as the experience of the workgroup members. While Doctor Templeton explained that the process was not perfect, the inputs submitted reflected the group's consensus of reasonable direct inputs for these codes. The workgroup recognized the that the methodology did not take into account multi tasking and the ability of clinical staff to perform some tasks simultaneously, but if the PEAC is able to develop a factor to reduce clinical staff times to account for this, such an adjustment should apply to all codes, not just the E/M codes.

PEAC members questioned why the Workgroup deviated form some of the standardized times developed and approved at the February PEAC meeting. The workgroup explained that the times required for vital signs and cleaning the room were higher than the previous PEAC recommendation based on the group's consensus. Although the PEAC developed standards in February for vital signs and room cleaning the PEAC agreed to change the standards to the following:

1. The obtaining of vital signs was standardized into 3 levels of service with the following times:
   Level 0 (no vital signs taken) = 0 minutes
   Level 1 (1-3 vitals) = 3 minutes
   Level 2 (4-6 vitals) = 5 minutes
2. Cleaning of the room and equipment was standardized to 3 minutes.

The PEAC discussed the extent that clinical staff perform tasks sequentially versus simultaneously but did not reach a consensus on qualifying the extent that this affects the workgroup recommendations. Doctor Opelka summarized a process employed to check on the validity of the workgroups times by comparing total available clinical staff time to the total time required based on the workgroup recommendations. The conclusion of this methodology was that the workgroup recommendations are overstated and an adjustment factor should be applied to reduce the inputs in a uniform manner. The PEAC discussed this methodology and offered suggestions as to how the methodology could be adjusted so that the total time available would not be exceeded by the time required to provide the E/M services. For example, it was suggested that for some specialties, increasing the number of clinical staff and increasing the number of hours staff work in a week would remove any inconsistencies. The PEAC did not take any action on applying an adjustment factor.

The PEAC approved the attached E/M Workgroup report that contains recommendation for the direct inputs for 15 E/M codes.

HCFA Clarification of Overhead Equipment

Carolyn Mullen presented several options to simplify the refinement of procedure specific and overhead equipment. The PEAC has had difficulty distinguishing between the two categories and Carolyn explained that most of the overhead equipment is also considered procedure specific. One distinction between the two categories is the utilization rate employed by HCFA. Procedure specific has a utilization rate of 50 percent while overhead has a utilization rate of 100 percent. HCFA has performed an initial impact analysis based on combing the two categories into one single equipment category. HCFA is currently discussing the possibility of eliminating the distinction between the two types of equipment and treat all equipment using a 50 percent utilization rate. Although there is not agreement within HCFA on this approach, Carolyn Mullen stated that this would simplify the refinement of the equipment inputs since specialties would have to only determine if a piece of equipment is medical equipment and if the equipment is typically used for the service. Such an approach would eliminate the need to decide what category a piece of equipment belongs in for a given procedure.

While the PEAC did not develop a specific recommendation on this proposal, the PEAC focused its discussion on the adjustments to the equipment utilization rate of 50%. Since this rate was arbitrarily developed by HCFA, some PEAC members wanted an opportunity to present data to HCFA that would demonstrate lower utilization for specific equipment. Other PEAC members questions how high of a priority this issue should be for the PEAC especially since the impacts from such changes are unknown, this issue needs to be addressed further. A informal workgroup met during lunch and based on their discussions, the following motion was presented and passed by the PEAC:

Specialty societies may identify high cost procedure specific equipment utilized less than 10% of the time, with the intent of providing the information to HCFA with the expectation

that HCFA will indicate the financial impact of revaluing the equipment utilization rates.

Doctor Berman recommended that the PEAC request HCFA to consider this motion first and if HCFA is agreeable to reviewing such input then specialty societies will be invited to identify equipment and codes than should have a different utilization rate. This input would then be provided to HCFA for analysis and then returned back to the PEAC for further review.

Another informal workgroup met during lunch to discuss a methodology for developing a basic pre-service time package. Doctor Opelka reported that the workgroup wanted to form a temporary workgroup similar to E/M workgroup. A survey would be used, which is similar to the RUC practice expense survey and this would be sent to all specialties to complete. The survey would be for a 90-day elective procedure selected by the specialty and the resulting times developed by the group would reflect a base time that could then be developed further to account for services that require additional clinical staff involvement. The workgroup discussed whether it should try to define the severity of the patient and the severity of the underlying condition, however it was determined this was too confusing and would have to be developed by each specialty. The PEAC agreed to form a workgroup consisting of the following members: Doctors Berman, Kwasny, Lee, Little, Opelka, Ouzounian, Przybylski, and Resnick. The workgroup will send a brief survey to all specialties, examine the results and meet via conference call with the objective of presenting at least a basic preservice clinical staff package to the PEAC at its next meeting.

Recommendations for standardized supply packages

Three recommendations for specialty standardized medical supply packages from the AANS and CNS, AAO and ACOG were presented and approved by the PEAC. These supply packages are attached to this report.

Doctor Przybylski presented the recommendations for standardized supplies for families of neurosurgery codes. A general neurosurgery package was developed based on the post op package developed by the PEAC in February with additional packages representing the neurosurgical subspecialty areas of craniotomy, spine and peripheral nerve. These additional post op incision care packages would be listed once in addition to the basic post op visit package. The PEAC approved these packages and the AANS agreed to forward to HCFA a list of codes that there supply package would apply to.

The attached Ophthalmology supply package was accepted without modification.

Doctor Berman explained the three ACOG proposed supply packages. The first represents a minimum supply package for office visits that is the same as the E/M package approved by the PEAC with the addition of disinfectant solution. In addition, a minimum supply package for a pelvic exam and a basic post operative incision care kit for ob-gyn services were approved.

OBGYN Facilitation Committee Report

Doctor Resnick reported that the facilitation committee agreed that the post operative clinical staff time should reflect a decreasing level of clinical staff work throughout the post service period. It was suggested that this could be represented by a decreasing level of post operative office visits. The facilitation committee also wanted to obtain input from the PEAC regarding the general methodology employed by ACOG since the facilitation committee agreed in concept with a process that determines the number and level of post operative visits in a global period for a particular code and then using the PEAC approved clinical staff times as associated with the appropriate level of E/M code. In addition, it was suggested that the time from discharge to the

first post op office visit entails a great deal of clinical staff time and this spans a time period of several days. After reviewing the ACOG inputs in detail the facilitation committee agreed to most of the time proposed for a post operative office visit, however, when this time is combined with certain activities included in the procedure, the facilitation committee felt there may be some duplication. Because of this issue as well as the assumption that all office visits represented a level three visits, ACOG proposed to withdraw their 10 and 90 day codes until the next PEAC meeting.

The PEAC was very supportive of the building block approach ACOG proposed and was suggested as a model for other specialties to follow with some modifications. As a result, the PEAC passed the following motion:

The PEAC will accept the concept of a specialty society's use of a building block approach for clinical labor for 010 and 090 global periods, based on E/M visits with adjusted time where appropriate.

Future Code Selection

In response to the following motion passed by the PEAC at its previous meeting, the PEAC continued its discussion of the development of a future workplan:

All representatives of the PEAC will come to the April PEAC meeting with their favored code selection criteria, either from the list provided in the PEAC staff note, or some other criteria. The April 2000 meeting is the final date at which a code selection criteria will be approved.

The following options were presented to the PEAC in February and Specialties were asked to select their favored approach.

- Codes that will the greatest change in practice expense relative values from 1998 to final transition in 2001, with frequencies greater than 10,000. The top 302 codes are listed in an attached table.

- Codes with the highest Medicare frequency. The 200 highest frequency codes are listed in an attached table.

- Codes that were reviewed by more than one CPEP ("redundant codes"). There are 645 codes that meet this criteria listed in an attached table.

- The RUC's Multi-Specialty Points of Comparison (MPC). There are 324 codes on this list and listed in an attached table.

- HCFA's validation panel list. 208 codes were included in the validation panel review and listed in an attached table.

- Codes that meet two or more of the above criteria. There are 304 codes that meet two or more criteria.

The PEAC discussed the merits of selecting one of the lists as well as focusing its efforts on developing standard clinical staff packages that could be applied across large numbers of codes. While the PEAC was supportive of standardizing inputs it agreed to focus first on those high frequency codes that experienced a large change in the PE RVU. The original table 2 was

reduced by only focusing on changes in the non facility PE RVU since HCFA officials explained that many of the changes in the facility PE RVUs was unrelated to the CPEP data but rather due to the creation of two sites of service. The PEAC agreed to focus on those codes with frequencies greater than 10,000 and that have a non-facility PE RVU increase of at least 200% or a decrease of at least 50%. This criteria resulted in a list of 122 codes. This list is attached. The PEAC agreed that these codes should be reviewed at the next PEAC meeting. Additionally, it was suggested that specialties should also present any other codes in the same family as the codes on the list. One approach would be to crosswalk the inputs for the code on the list to the other codes in the same family.

To facilitate the review of data presented to the PEAC, Doctor Moran suggested several options for ensuring that the direct input data reached the PEAC members several weeks prior to next PEAC meeting. One suggestion was to assign the codes to facilitation committees for review either prior to the meeting or for review on the first day of the meeting. These committees would then be able to review the data in detail prior to presentation to the entire PEAC. The PEAC agreed that such a approach would improve the review process and it was agreed that the dates that input data would need to be submitted will be moved up to allow for early printing of the agenda book.

Practice Expense Advisory Committee
E/M Workgroup
Recommendations to the PEAC

The Workgroup was comprised of the following members**:** Doctors Neal Templeton, (Chair), Tom Felger, Greg Kwasny, Frank Opelka, Emil Paganini, Jeff Resnick, Ronald Shellow, Daniel Mark Siegel, and Charles Weissman. The charge of the Workgroup was to develop a recommendation for the direct inputs for the for the E/M codes for the PEAC to consider during the April PEAC meeting. The recommendations are summarized below and also contained in the attached Table 1. The E/M Workgroup held six conference calls from February 23 to April 5, each typically lasting 1.5 hours.

Code Selection
The workgroup initially decided to focus on 15 office based E/M codes that currently have CPEP data and have high frequencies:

Office or Other Outpatient Services:
New Patient 99201-99205
Established Patient 99211-99215
Office or Other Outpatient Consultations 99241-99245

As a first step in refining the data, the workgroup decided to pick an anchor code from each of the three groups of codes. It was agreed to use 99203, 99213, and 99243 as the initial anchor codes. The level 3 codes were felt to be fairly representative codes with high frequencies and would serve as a starting point for further refinement. The workgroup then narrowed the number of CPEP inputs from further review and decided to focus its efforts on using CPEP 7 as a benchmark for further refinement. The workgroup felt that CPEP 7, which was the evaluation and management CPEP appeared to have reasonably consistent times.

Staff Level
The workgroup concluded that a blend of RN/LPN/MA would be the most representative staff blend given the wide range of staff utilized across specialties and the wide range of practice settings, even within specialties. After discussing comments received from the American College of Surgeons that supported the use of this blend, the workgroup concluded that such a blend would be the most appropriate blend for all of the E/M codes under review. However, the workgroup did not agree to quantify specifically how teach staff type was utilized, but instead recommended that the blend would be applied to any clinical staff time assigned to the E/M codes.

Clinical Staff Time
The workgroup began developing clinical staff times with code 99203 by assigning times for each applicable staff activity. The workgroup members then individually assigned times for the remaining 14 codes and during a later conference call, these times were reviewed, revised, and then averaged. The committee then reviewed the clinical staff times and the ratio to physician times as a check on the relativity on the estimates. The workgroup felt that the relativity for each group of five codes was accurate, however, the differences across families for each level of code were explored. The workgroup used these ratios as a check on the relativity of the staff time estimates. In general, the workgroup concluded that the ratio of clinical staff time to physician time decreases as the level of code increases. Tables 2 and 3 attached to this recommendation, display the various ratios of clinical staff time to physician time, both the total physician time, as

defined by HCFA, and the CPT face to face time. Table 4 compares the workgroup time recommendations to CPEP 7 times.

The clinical staff times were then distributed to the PEAC members and all RUC participants for comment. After reviewing all comments received from specialties, the workgroup made several changes to clinical staff time on a code by code basis. The workgroup only made those changes where there was a clear consensus that the recommended change included a strong rationale. Absent new evidence or rationale, the workgroup opted to leave the recommendations intact so the PEAC could discuss as a group. These changes are discussed below.

Further Clarification of Workgroup Recommendations

- One commenter questioned the Workgroup's decision to include pre-service time for codes 99201-99205. Since these are new patients who have not received prior treatment, the commenter suggested that there should not be any prior reports or records to review prior to the appointment. The workgroup concluded that although these codes are for new patients for a particular physician, these patients typically have previous medical records that need to be reviewed prior to an initial visit. Given the trend of patients changing health plans and then physicians, the workgroup felt that although the patients are new, they do have existing medical records that are reviewed. The Workgroup also discussed the extent of the medical record review by staff and maintained the originally recommended times.

- A commenter recommended that the previously approved RUC times for vital signs and room cleaning should be maintained. The workgroup discussed the possibility of standardizing the time for vital signs but felt that the original Workgroup recommendations reflected the increased times for the higher level codes. Also, although the PEAC previously concluded that one minute should be assigned for cleaning the room, the workgroup felt that it should be increased to three minutes. In addition, the workgroup discussed that some specialties will need to increase the room cleaning time to account for a specialty specific differences if these E/M codes are incorporated into codes with global periods.

- The workgroup reviewed comments suggesting both increases and decreases in the post service period. One commenter felt that the phone call times are excessive in both time and frequency and another felt that the time allocated was insufficient. The Workgroup only adjusted the post service time for codes 99203 and 99204 to maintain consistency.

- One commenter stated that the overhead equipment should be considered an indirect expense rather than directly associated with a particular code. The Workgroup agreed that equipment such as defibrillators that are not typically used are overhead equipment. Therefore, using them as an allocator of direct expense in the same manner as clinical labor, is very questionable. The PEAC has discussed this issue at length and has been unable to clarify the methodology that considers overhead equipment as a direct input. Given the existing methodological constraints, the Workgroup felt that the CPEP 7 inputs were valid.

Multitasking

The current HCFA methodology requires the development of an estimate of the time required to provide the services to a typical patient, therefore the clinical staff times can not account for the times when staff perform several tasks simultaneously. The workgroup agreed that allocating specific nurse times to CPT codes is a difficult task since nurses typically spend their day multitasking. However, but allocating time to a CPT code and assuming a single task minute, staff only perform each single task sequentially, and never perform two tasks at the same time

such as greeting the patient and preparing the room. Due to the estimates assigned to each discrete task, the total for specific CPT codes may be somewhat inflated due to multitasking.

This issue was discussed in detail by the Workgroup. In an attempt to account for the effect of multitasking, the American College of Surgeons (ACS) submitted to the Workgroup for discussion during the April 5 conference call, a proposal for reducing the workgroup's recommendations. The ACS approach compared available clinical staff minutes for a year to the number of minutes required to provide the E/M codes given the Workgroup's preliminary times estimates. This analysis concluded that when the Workgroup's recommendations are used, the total time required to provide E/M services to Medicare patients exceeds all available clinical staff time. Therefore, as a reality check, the ACS recommended that the Workgroup developed times should be decreased by a fixed percentage to be more closely aligned with total available clinical staff time.

The Workgroup agreed that multitasking affects the clinical labor inputs for all codes and if an adjustment is needed, it should be made to all codes, not just the E/M codes. At this time the Workgroup was unable to agree on a method for quantifying a factor to account for multitasking.

Medical Supplies

The workgroup considered the standard basic visit package developed by the PEAC as well as the supplies assigned to all the CPEP 7 E/M codes. The workgroup felt that combining the two supply groups appeared reasonable and agreed that the following supplies should be applied to all the E/M codes and would constitute the standard supply package for E/M office visit and consultation codes. However, based on one specialty's comments, the number of patient education booklets was reduced from 2 to 1.

Medical Supplies

drape, sheet	1 item
exam table paper	7 feet
pillow case	1 item
gloves, non-sterile	2 pair
otoscope speculum disposable	1 item
patient education booklet	1 item
patient gown, disposable	1 item
swab, alcohol	2 item
thermometer probe cover, disposable	1 item
tongue depressor	1 item

Overhead Equipment

While many aspects of HCFA's practice expense methodology as it relates to overhead equipment have not been fully explained by HCFA, the workgroup felt that the CPEP 7 overhead equipment lists should apply to all E/M codes. The exam table and crash cart, no defibrillator seemed reasonable pending further refinement of the overhead equipment category. In addtion, the PEAC added an otoscope-opthalmoscope to the overhead equipment list.

Procedure Specific Equipment

The workgroup agreed that these codes would not contain any procedure specific medical equipment. This is consistent with the CPEP 7 data.

Conclusion

The workgroup recognizes that the existing methodology requires the development of inputs based on a typical patient, however, the use of clinical staff resources to support E/M services varies not only by specialty, but by practice type. Therefore, the recommended inputs that reflect the resources used across the wide range of specialties and practice types and geographic locations was based on the collective input of Workgroup members. The intent of the workgroup is to have its recommendation serve as a benchmark for future PEAC work. For example, individual specialty estimates of direct inputs for the office-based E/M components of services with global periods may differ from these Workgroup recommendations, and specialties might need to adjust the inputs to reflect specialty specific requirements. Therefore, the Workgroup has attempted to develop recommendations that are based on a "typical" E/M patient as much as possible while recognizing that these same codes are used by different specialties.

Attachment 1

The following summary of 99203 is provided as representative of the Workgroup discussions surrounding each code.

Clinical Services

Pre-Service Period ***Start: When appointment for service is made***	The workgroup agreed that for this code, there was very little preservice clinical staff work that occurs prior to the patient arriving at the office. Because some specialties do require clinical staff to spend some time reviewing reports prior to the appointment, the workgroup assigned 2 minutes to the preservice time period.
Review/read X-ray, lab, and pathology reports	
Other Clinical Activity (please specify) _____	
End: Patient arrival at office for service	
Service Period *Start: Patient arrival at office for service*	The workgroup agreed that the PEAC assignment of 3 minutes for greeting the patients appeared reasonable.
Greet patient/provide gowning	
Obtain vital signs	While the PEAC assigned 4 minutes for this activity, the workgroup felt that is was slightly low for this code and recommended 5 minutes as more typical.
Prep and position patient	This time varies by specialty, with most having minimal time, however, some specialties such as Orthopedics and OBGYN, might require a greater amount of time. The workgroup assigned 2 minutes for this activity.
Review history, systems, and medications	This category was not on the survey, but the workgroup identified these activities as a separate, distinct and significant portion of clinical staff activities. This involves obtaining history information from the patient, reviewing forms with the patient and obtaining accurate medication history information. The nurse will also review the patient's history and assist with documentation, such as with the medication list. The workgroup decided that 12 minutes appeared reasonable.
Prepare room, equipment, supplies	Two minutes was assigned to this activity of making sure that the needed supplies were available for the physician. Depending on the specialty, the time required for this activity will vary, but 2 minutes seemed typical.
Assist physician during exam	Based on the typical 30 minutes that the physicians spends providing this service, the workgroup felt that the clinical staff is only preset during the exam for a small portion of the time. Depending on the exam, clinical staff may be required to be present and would spend a

	greater amount of time with assisting the physician. After considering all these factors the workgroup agreed to 5 minutes for this time period.
Education/instruction/ counseling	Similar to reviewing history, the workgroup felt that this activity required significant amount of time with the patient and assigned 9 minutes.
Coordinate home or outpatient care	The workgroup assigned 2 minutes to this code.
Clean room/equipment	The PEAC assigned 1 minute to this activity based on the time required to scan the room and change the exam table paper. The workgroup felt that additional time was required to clean up any supplies and ensure the room was clean. The workgroup assigned 3 minutes to this activity.
Other Clinical Activity (please specify) _____	
End: Patient leaves office	
Post-Service Period **Start: Patient leaves office**	The workgroup initially decided that on average, 2 phone calls averaging 2.5 minutes are conducted during this time period. This time was based on a study of practices by the American Academy of Opthamology and utilized for their review of practice expenses. The workgroup ultimately decided that while this can serve as a guide, the workgroup agreed that on average 6 minutes is spent making telephone calls.
Phone calls between visits with patient, family pharmacy	
Other Activity (please specify)	
End: When appointment for next office visit is made.	

A total of 51 minutes was assigned to 99203.

Table 1 E/M Workgroup Results Through a series of meetings, the E/M Workgroup developed the following table of average clinical labor time for each of the following E/M codes. Clinical labor time is broken out by specific clinical activities. Due to rounding of the specific staff activities (determined via inputs of multiple physicians), the total for each code may not equal sum of staff activities for each code. The total time row indicates the RUC recommendation.

	99201	99202	99203	99204	99205	99211	99212	99213	99214	99215	99241	99242	99243	99244	99245	Average
Pre-Service Period																
Start: When appointment for service is made																
Review/read X-ray, lab, pathology reports	-	1	2	4	4	-	1	2	3	4	1	2	3	4	4	2
Other Clinical Activity (please specify)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
End: Patient arrival at office for service																
Service Period																
Start: Patient arrival at office for service																
Greet patient/provide gowning	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Obtain vital signs	3	4	5	5	5	2	4	5	5	5	3	5	5	5	6	4
Prep and position patient	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	2
Review history, systems, and medications	5	10	12	15	15	4	5	6	13	15	5	10	15	15	16	11
Prepare room, equipment, supplies	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Assist physician during exam	1	3	5	6	8	-	2	3	5	6	3	4	5	6	8	4
Education/instruction/counseling	4	5	9	11	12	3	3	5	9	9	4	6	9	12	13	7
Coordinate home or outpatient care	-	-	2	3	9	-	-	-	2	6	-	1	3	5	8	1
Clean room/equipment	3	3	3	3	3	2	3	3	3	3	3	3	3	3	3	3
Other Clinical Activity (please specify)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
End: Patient leaves office																
Post-Service Period																
Start: Patient leaves office																
Phone calls between visits with patient, family, pharmacy	1	4	6	8	9	1	4	5	6	8	2	3	6	6	9	5
Other Activity (please specify)																
End: When appointment for next office visit																
Total Time	24	38	51	62	71	16	27	36	53	63	27	40	55	63	73	44

AANS CNS Recommended Supply Packages

Recommended Per Visit Package (Multiply by total number of post-surgical visits)		Current CPEP Data for 90-day Global Neurosurgery Codes	**New Neurosurgical Recommendations**
Patient Gown	1	1	**1**
Exam Table Paper	7	7	**7**
Pillow Case	1	1	**1**
Gloves Non-sterile	2	2	**2**
Thermometer Probe Cover	1	0	**1**

Recommended Post-op Incision Care Kit (List once in addition to above)		Current CPEP Data for 90-day Global Neurosurgery Codes	**New Neurosurgical Recommendations**			
			Standard	**Craniotomy**	**Spine**	**Periph Nerv**
Gloves Sterile, pr.	1	0	**1**	**1**	**1**	**1**
Swab Alcohol	2	1	**2**	**2**	**2**	**2**
Gauze Sterile	2	2	**2**	**4**	**4**	**2**
Steri-strips	12	0	**12**	**12**	**12**	**12**
Tape, (inches)	12	0	**12**	**60**	**36**	**18**
Staple Removal Kit	1	0	**1**	**1**	**1**	**1**
Betadine (ml)	20	0	**20**	**20**	**20**	**20**
Tincture Benzoin Swab	1	0	**1**	**2**	**2**	**1**
Suture Removal Kit	0	1	**1**	**1**	**1**	**0**
Kling	0	2	**0**	**1**	**0**	**1**
Patient Education Book	0	1	**1**	**1**	**1**	**1** (provided pre-op or at initial post-op visit)

ACOG

Medical Supply Packages for Ob-Gyn Services

A. Minimum Supply Package for Office Visits

Supply Code Number	Description	Quantity
Multi-specialty minimum supply package for visits (developed by PEAC 2/00):		
11107	Patient gown, disposable	1 item
11111	Exam table paper	7 foot
11112	Pillowcase, disposable	1 item
11302	Gloves, non-sterile	2 pair
11509	Thermometer probe cover, disposable	1 item
ACOG Addition:		
52314	Disinfectant solution	0.2 oz

B. Minimum Supply Package for Pelvic Exam

Supply Code Number	Description	Quantity
31105	KY jelly, single use pack, 5 grams	1 item
31511	Mini pad	1 item
11507	Speculum, disposable	1 item
11513	Swabs, procto	2 item

C. Basic Post-Operative Incision Care Kit for Ob-Gyn Services

Supply Code Number	Description	Quantity
Basic Post-Operative Incision Care Kit (developed by PEAC 2/00):		
14005	Gloves, sterile	1 pair
31101	Swabs, alcohol	2 item
31513	Steri-strips	2 package
31514	Tape	12 inch
31702	Staple removal kit	1 item
52301	Betadine	10 ml
31505	Gauze, sterile 4 x 4	1 item
52308	Swab, tincture benzoin	1 item
ACOG Addition:		
11106	Drape, sheet	1 item

Type of Visit	**Basic Supply Package**
Ob-gyn office visit with pelvic exam	**A + B + drape sheet (1 item, supply code 11106)**
Ob-gyn in-office procedure	**A + B + sterile gloves (1 pair, supply code 14005) + drape sheet (1 item, supply code 11106)**
Ob-gyn post-operative incision care visit	**A + C**
Ob-gyn post-operative incision care visit with pelvic exam	**A + B + C**

	Proposed Ophthalmology Visit Package					
	(x Number of Visits)					
11110	pad, chin rest	1 item				
11121	post myd spectacles	1 pair				
11302	gloves, non-sterile	2 pair				
31101	swab, alcohol	2 item				
31103	cotton tipped applicators	2 item				
52306	glutaraldehyde	1 ounce				
53013	fluorsine strips	1 item				
53065	mydriacil 1%	.1 ml				
53073	rev eyes	.1 ml				
53074	ophthaine	.1 ml				
53076	myolfrin 2.5%	.1 ml				
NOTE: the above list represents those supplies that are used in every visit for a given procedure or service.						
The AAO recommends that the above supply package be applied to codes with global periods that include post operative visits and fall within the following range of codes: 65091- 67999. For example if two visits are listed for a particular code, the above package should be assigned to each visit.						

FACILIATION COMMITTEE
PERCUTANEOUS MANAGEMENT OF DIALYSIS GRAFT/FISTULA

The Facilitation Committee met on April 29, 2000 to discuss code *3686X Thrombectomy, percutaneous arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* which has a recommended work RVU of 6.85 which is the survey median work value.

The Committee identified that there are three services that will always be provided together; new code 3686X (Societies' recommended RVW of 6.85; 090 global), 36145 (RVW 2.01), and 75790 (RVW .54).

3686X	6.85
36145 (2.01 * .5)	
(50% reduction)	1.00
75790	1.84
	9.69

The Committee reviewed 36831 (RVW 8.00; 090 global) "Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft." If this service is reduced by 1.00 and 1.84, the resulting RVW is 5.16.

The Committee also reviewed 36860 (RVW 2.01; 000 global) "External cannula declotting; without balloon catheter" and 35473 (RVW 6.04; 000 global) "Transluminal balloon angioplasty, percutaneous; iliac" and determined that this 3686X was roughly in this range. The Societies' agreed to a value of 5.16, recognizing that it also incorporated a 090 global. **The Committee recommends a RVW of 5.16.**

AMA/Specialty Society RVS Update Committee
Health Care Professionals Advisory Committee

April 27, 2000

I. Term Limits

The Health Care Professional Advisory Committee (HCPAC) met during lunch on April 27, 2000 and discussed the terms limits of the HCPAC members. Currently, the RUC's Structure and Functions states that "Representatives to the HCPAC shall hold terms of three (e) years, with a maximum tenure of six (6) years."

The HCPAC requested two meetings ago that the term limits of the HCPAC be extended due to the complexity of the work associated with the seat. A vote was made to have the societies review the recommendation and present at this meeting, a vote for elimination of tenure. Doctor Whitten announced that this would require a revision of the RUC's Structure and Functions.

The following unanimous recommendation for an editorial change to the RUC Structure and Functions terminology was made:

III. C. (4) Term:
(a) Representatives to the HCPAC shall hold terms of three (3) years ~~with a maximum tenure of six (6) years.~~

II. Relative Value Recommendations

The HCPAC members proceeded to discuss the recommendations for Development of Cognitive reasoning. During the discussion for code 975X1, the HPCAC members felt that the pre and post service times for this code were inappropriately combined. The rationale does not explain how the work relative value was arrived at, since AOTA has a recommended work relative value of .50 and APA has a recommended work relative value of .725.

A representative from HCFA mentioned that it was important for the specialty's to itemize their practice expense inputs in a method similar to the Practice Expense Advisory Committee (PEAC). In addition, HCFA mentioned that equipment has to be typically used for that specific procedure. Furthermore, HCFA clarified that medical supplies should be truly disposable and typically used for each session, and HCFA questioned the clinical labor time spent in cleaning the room. The specialty society agreed that an itemization methodology such as the PEAC's should be incorporated into their presentation and requested the necessary forms from AMA staff. The specialty proceeded to explain that the clinical labor time involved in cleaning the room was indeed for each session and not once a day.

A motion was made for the HCPAC to table the relative value recommendations until a

conference call may be convened soon after this meeting and the specialty society may return with new and revised work recommendations and practice expense input recommendations.

III. Other Issues

Currently, the HCPAC's organization Structure and Processes document states, "For codes used only by non-MD/DO's, the RUC/HCPAC review board will replace the RUC as the body that is responsible for developing recommendations for HCFA."

The Review Board reviewed the current procedure in place to identify these services. Currently, the codes are referred to the HCPAC only when no MD/DO organization has expressed an interest in surveying the new codes. Therefore, a new code which is overwhelmingly performed by non-MD/DO providers maybe on the RUC agenda when a small subset of physicians report this service and wish to develop a recommendation on the new service. Accordingly, the Review Board recommends the following motion:

Where only a small portion of the use of a code is performed by MD/DO's (less than 20%) and a survey is done by a HCPAC member organization, the survey results shall be presented to the HCPAC. **Doctor Hoehn referred this issue to the Administrative Subcommittee to review.**

HCPAC members were concerned about establishing criteria for HCPAC membership and wished to develop steps for when non-membership groups would report to the RUC. Currently, a society has to have a seat on the RUC or cooperation through another specialty in order to present recommendations to the RUC. The HCPAC Chair requests that the RUC appoint a subcommittee to look into this issue.

HCPAC members question what role they will play in the upcoming five-year review. Doctor Whitten stated that there are only 12 HCPAC issues for the five-year review, which will be addressed at the October meeting.

AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee
April 30, 2000

The following members of the Practice Expense Subcommittee met on April 28, 2000 and reviewed the subcommittee's task of comparing RUC physician time to HCFA's total physician time. Doctors John O. Gage (Chair), J. Leonard Lichtenfeld, John Mayer, Jr., David McCaffree, Robert Zwolak, Melvin Britton, Sheldon Taubman, and Walter Smoski, PhD.

Doctor Gage began the discussion by bringing the group up to date on the issue of calculating RUC physician time. HCFA requested in September 1999, total physician time for all codes contained in the RUC database, therefore this Subcommittee and AMA staff have been in the process of collecting missing time data elements from the specialty societies. Since the Subcommittee agreed in February 2000 that the RUC should use the HCFA post-five year review for office and hospital visits time currently utilized by HCFA, AMA staff were directed by the RUC to calculate total physician time using these new times and conduct a side by side comparison. When AMA staff attempted to carry out this calculation, it became apparent that it could not be performed without further specialty society input. For many codes, the post-operative visit data include total number of visits and total time, but not the level of visit. The RUC has recommended that total time be used for these E/M visits in a consistent manner across all codes with a global surgical period, however, for a number of codes the level of each E/M service needed to be identified by specialty societies before the adjustment could be made.

AMA staff, on March 2, 2000 sent out a memo requesting selected specialty societies to submit missing numbers and levels of hospital and office visits where appropriate, without deviation from what was currently in the RUC database. Most of the specialty societies contacted responded to AMA staff's request for data, however, some data still needs to be provided before AMA staff can calculate total physician time and perform a side by side comparison between RUC time and HCFA time. Doctor Gage explained that **if the data was not supplied by the specialties involved, the default office visit level would be 99213, the level HCFA's contractor used originally to calculate current HCFA physician time.** It was noted that it was important for specialties to submit the missing data.

Sherry Smith outlined what AMA staff needed from specialty societies for the next Subcommittee meeting, so that the Subcommittee can analyze and review the data before sending it to the RUC.

1. **For those specialties that have not submitted the missing hospital and office levels to AMA staff, that they do so.**
2. **For codes where multiple specialties have submitted different hospital and office levels, those societies must come to a consensus because HCFA needs one time for each code.**
3. **For those specialties who submitted different numbers of hospital or office visit numbers than what is in the RUC database, to resubmit correct numbers and levels. Hospital and office visit numbers should not deviate from the RUC database since the RUC database information comes directly from specialty recommendation forms.**

Doctor Florin identified several codes that where reviewed by the RUC prior to the five year review, where the RUC only collected a total time for the post operative period. This included all time from the closure to discharge, and all this work was reflected in a single time number. Doctor Florin suggested that specialties use length of stay to first identify the number and level of hospital visits, and then take the remainder of time and allocate it to office visit number and level. Specialties would use CPT time in these time and level determinations and then the time associated with these visits would be adjusted to the post five year review E/M times to be consistent with the calculated times of post five year review codes. It was reiterated that the purpose of this data collection effort was to fill in missing data items in the RUC database so the total

physician time can be calculated and compared to the total physician time data that was calculated by HCFA. Since HCFA has been unable to explain how they calculated total RUC physician time, the RUC has determined to calculate total RUC physician time so it can be compared to HCFA's computed values prior to forwarding RUC time to HCFA.

HCFA representatives mentioned that physician time from the RUC would be reviewed and implemented depending when the RUC would forward it. Members of the subcommittee expressed their concern over the impact of the RUC time implementation and asked for an impact analysis from HCFA. Doctor Lichtenfeld expressed additional concern that since HCFA is currently conducting several independent physician time studies, that the results of these studies may be quite different than what the RUC has approved.

Doctor Lichtenfeld also expressed concern that if specialty societies arbitrarily select the hospital numbers and levels through the above discussed process, it is a departure from the RUC's reliance upon survey data results. Doctor Gage explained that **it would be up to the Practice Expense Subcommittee to analyze and review the submitted data at he next meeting, (a large task), and then send it to the RUC**. A Subcommittee member suggested that all new inputs developed by Specialties should be clearly identified on the data forms presented to the Subcommittee so they can be readily identified. Since the RUC survey has changed over the years it would also be helpful to know what year the RUC reviewed the codes so the additional items could be distinguished from the original data.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
April 27, 2000

On April 27, 2000, the Research Subcommittee met to discuss several issues relating to the RUC work survey, five year review methodology employed by specialties, future SMS activities, review of HCFA practice expense methodology, and discussion of a HCFA proposal to revise the medical equipment categories. The following subcommittee members were in attendance: Doctors Bruce Sigsbee (chair), Joel Bradley, Robert Florin, William Gee, Richard Haynes, David Hitzeman, David Massinari, James Moorefield, Eugene Weiner, and Don Williamson, OD.

RUC Survey
The Subcommittee discussed various changes to the RUC work survey and determined not to change the survey format to limit the number of CPT codes listed per day in the post service period as well as not changing the format to collect inpatient visit information separately from office visit data. When there is more than one visit per day, survey respondents are instructed to list the additional CPT codes provided to identify the type of services provided. The subcommittee concluded that the current format allows the collection of more accurate data and is simpler for respondents to complete.

The Subcommittee discussed the usefulness of the questions relating to intensity of the service and concluded that in order to simplify the survey the questions need to be revised. Some members questioned the usefulness of the specific measurements rather than a general understanding of the intensity based on medical knowledge. The Subcommittee eventually agreed that the intensity questions contained in question 4 that measures specific aspects of intensity needed to remain in the survey since this intensity information is needed to determine the relativity of the code being reviewed. However, the subcommittee felt that removing question 3 would simplify the survey.

The Subcommittee passed the following motion:
- Question 3, which asks for a rating of the intensity of the pre, intra, and post service periods shall be eliminated from the survey.

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

The Subcommittee discussed the usefulness of surveying time data for reference services. The current RUC methodology instructs respondents to select a reference service and provide time and intensity estimates for the reference service along with the service being reviewed. The purpose of requesting this information has been to provide the respondent with a framework to better determine the relative value of the new or revised code. Some Subcommittee members agreed with this approach and liked to know the resurveyed times of reference services to get an idea of what the current survey group thought the relativity between the codes is currently. This gives an indication of the quality of survey responses to see if they have a totally different concept of time for the reference code. Not asking respondents to select physician time for the reference code would simplify the survey. The time data associated with the reference code that should be provided was then discussed. While providing time data may assist respondents, there are various sources of time data available, and the RUC has yet to resolve many of the HCFA adjustments made to RUC and Harvard time data. However, it was suggested that a hierarchy of value of time data exists with RUC time having more validity than Harvard time.

The Subcommittee passed the following motion:

- The RUC will not survey the time for reference codes. Specialties should include time in the survey for reference services with references provided by specialty society to indicate the source of the time (i.e. RUC, or Harvard) . Include both total time and any pre, intra, and post time when available.

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

To assist the RUC in determining the reason why codes were included in the five year review **the RUC agreed to add the following questions to the RUC work survey for use in the five year review:**

Has the work of performing this service changed in the past 5 years? ___ Yes ___ No.
If yes, complete a - c.

a. This service represents new technology that has become more familiar (i.e., less work).
__ I agree __ I do not agree

b. Patients requiring this service are now:
__ more complex (more work) ___ less complex (less work) ___ no change

c. The usual site-of-service has changed:
__ from outpatient to inpatient __ from inpatient to outpatient __ no change

The rationale section of the Summary of Recommendation form was also updated to include the following instruction: "Your rationale should also describe how the work of performing the service has changed over the past five years"

Alternative Methodologies for Developing Work Relative Values
The American College of Surgeons (ACS) presented a proposed building block methodology. The ACS is proposing to use this methodology to revalue 322 code submitted for the five year review. The methodology is explained in detail in the material contained in Tab P of the RUC agenda book, and a summary is attached. The methodology multiplies pre-service time broken into scrub/dress and pre-op evaluation by two separate intensity factors to obtain a pre-service RVW. Then intra service RVWs were calculated by multiplying the IWPUT by intra time. The ACS assigned IWPUTs and used consensus panels of 16-18 surgeons to review benchmark codes and their assigned IWPUTs. Post service RVWs were calculated using current RVWs for hospital visits and "discounted" RVWs for office visits. The sum of the pre intra and post RVWs were summed to equal the total RVW. The Subcommittee discussed how to define the building block technique and the IWPUT calculations.

The SVS discussed their building block methodology that was similar to the ACS's but also used RUC work surveys to validate their results. For low volume codes, the SVS used a mini survey that was added on the survey for higher frequency codes. Answers are based on completing the full survey for a code being reviewed, to rank the code in comparison to the code just evaluated.

The RUC passed the following motion:

- **The use of a minisurvey should be restricted for low volume codes to fill in gaps within a family of codes.**

The Subcommittee first discussed the calculation of pre-service RVWs and the use of intensity factors for this time period. The original Harvard methodology divided pre-service into the cognitive evaluation time and the time involved with scrub and dress. Each had a separate intensity factor.

The Subcommittee passed the following motions:
- The original Harvard pre-service RVW formula with two levels of intensity; .0224 for evaluation and .0081 for scrub should be used.
- Only the pre-service times for the categories of evaluation and scrub/dress that are developed by surveys should be used in calculating pre-service RVWs.

The RUC did not approve the above motions regarding the use of the separate intensity factors.

The Subcommittee discussed various ways to calculate the IWPUT, ranging from assigning IWPUTs according to a scale or calculating by backing out pre and post service work. The ACS developed their IWPUTs by a panel and assigned the IWPUTs to benchmark codes. The ACS presenters stated that this was valid since the original Harvard ranges they used were from .031 and .108 and 90% of codes fall within this range.

While some Subcommittee members felt that providing a rage of values and then assigning IWPUTs to codes is preferred to the formula approach that can create negative IWPUTs, others felt that providing a scale would influence the results and that any data would need to be validated by a survey.

The RUC passed the following motion:
- **The RUC reaffirms its action on intensity of September 27, 1997 and allows intra-service intensities and times to be developed by surveys or a consensus panel and be presented as relative intra-service work per unit time numbers. The use of this information in no way changes the current RUC policies regarding the use and interpretation of IWPUT information.**

> Intra-service intensity or IWPUT should be used only as a measure of relativity between codes or in families of codes. IWPUT is a complimentary measure and should not be used as the sole basis for ranking or the assignment of value to a service. The workgroup further observes that most formulas for the calculation of IWPUT use imputed values, there is no preferable formula.

To calculate the post service work the subcommittee discussed the use of discounted E/M equivalent values as the preferable method rather than just using time and multiplying by an intensity factor. **The RUC passed the following motion**:

- **In calculating post procedure service work, discounted E/M equivalent values should be used.**

ASA Presentation

The ASA presented its plan to use a building block approach using a group of E/M services that describe several components of anesthesia care. The value of the building blocks are compared with an imputed value of the anesthesia base plus time methodology and conversation factor to establish the appropriate physician work value. The data for five service elements of providing anesthesia work is collected via survey. Also, a consensus panel evaluates the survey results and determines the most appropriate E/M codes that represents the physician service during the various service periods. The total building block value is then compared to an imputed anesthesia work value using a formula.

The RUC passed the following motion:

- **Approve the methodology proposed by ASA with the validity of the individual data components to be determined by the RUC.**

SMS Survey Status
Sara Thran explained that the SMS survey is no longer feasible as originally designed. The response rate has been decreasing and the cost of the survey has been increasing. Given these difficulties, the AMA conducted a pilot practice survey this year and had planned to field the full practice-based survey later this year if the pilot was successful. Given the recent AMA restructuring, the data collection activities have been put on hold.

The AMA expects to be involved in data collection again in the future and the Health Policy Group has formed a practice expense data collection workgroup to develop a strategy for the AMA on practice expense data collection. This workgroup will address such issues as the RUC's needs for practice expense data, data collection methodologies, and the potential for a consortium with specialty societies. In addition, the group will discuss what role, if any, the AMA should play in assisting specialty societies to collect their own practice expense data.

The Subcommittee discussed the various benefits of having the AMA collect physician practice expense data and the RUC passed the following motion:

- **The Subcommittee recommends the continuation of the SMS survey of practice expense data since the SMS survey is recognized as one of the most valuable activities of the AMA that benefits all physicians.**

Lewin Report on HCFA Practice Expense Methodology
The Lewin officials summarized their work to date on this issue. In particular, the various methods for validating future SMS physician time data was discussed. The Lewin officials concluded that the SMS data matches a MGMA data set and is internally consistent when compared to the Harvard RUC time data. The next Lewin report will be delivered to HCFA next month and this report will address the indirect expense allocation methodology. Lewin staff will also remain involved in this issue to answer questions from specialty societies regarding the collection of supplemental practice expense data. HCFA anticipates publishing a new regulation that outlines criteria for specialties to follow when submitting supplemental practice expense data.

HCFA Clarification of Overhead Equipment
Carolyn Mullen presented several options to simplify the refinement of procedure specific and overhead equipment since a clear definition of overhead and procedure specific equipment has not been developed. Carolyn explained that most of the overhead equipment is also considered procedure specific equipment. One option is to delete all overhead equipment but then to be

consistent, the procedure specific equipment would need to be cleaned up to remove equipment that may really be overhead. This would have significant impacts and is not being proposed.

Another proposal is to merge the two equipment categories, which currently are distinguished by the use of different utilization rates. Procedure specific equipment has a utilization rate of 50 percent while overhead equipment has a utilization rate of 100 percent. HCFA is currently discussing the possibility of eliminating the distinction between the two types of equipment and treating all equipment using a 50 percent utilization rate. When the categories are combined, then true overhead equipment should not be used as an allocator. While the total impact of making this change is unknown but initial indications from HCFA are that the impact may be minimal. Although there is not agreement within HCFA on this approach, Carolyn Mullen stated that this would simplify the refinement of the equipment inputs since specialties would have to only determine if a piece of equipment is medical equipment and if the equipment is typically used for the service. The Research Subcommittee did not made a recommendation on this issues due to the apparent lack of agreement within HCFA, but a Subcommittee member pointed out that although HCFA staff may disagree on the best approach, HCFA has a responsibility to submit an accurate impact analysis as requested by the RUC in February.