AMA/Specialty RVS Update Committee
April 26-29, 2001

Hotel InterContinental Chicago
Chicago, Illinois

I. Welcome and Call to Order

Doctor James G. Hoehn called the meeting to order on Thursday, April 26, 2001 at 8:30 am. The following RUC members were in attendance:

James G. Hoehn, MD, Chair
James Blankenship, MD
James Borgstede, MD*
Joel Bradley, MD
Brett Coldiron, MD*
John Derr, MD*
Lee Eisenberg, MD
Thomas Felger, MD*
Robert Florin, MD
John Gage, MD
William Gee, MD
Gary Gramm, DO*
Alexander Hannenberg, MD
James Hayes, MD
David Hitzeman, DO
Charles Koopmann Jr., MD
M. Douglas Leahy, MD*
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
Charles Mabry, MD*
James D. Maloney, MD*
David L. Massanari, MD
John Mayer, MD
David L. McCaffree, MD
James Moorefield, MD
Bill Moran, MD
Bernard Pfeifer, MD
Alan L. Plummer, MD
Greg Przybylski, MD*
Sandra Reed, MD*
David Regan, MD
James Regan, MD*
William Rich, MD
Peter Sawchuck, MD*
Chester Schmidt, Jr., MD
Paul Schnur, MD
Bruce Sigsbee, MD
J. Baldwin Smith, MD*
Sheldon Taubman, MD
Trexler Topping, MD*
Richard Whitten, MD
Don E. Williamson, OD
Robert Zwolak, MD

* Alternate

II. Chair's Report

Doctor Hoehn welcomed the RUC members and made the following announcements:

- Doctor Ted Lewers has been invited to attend the RUC meeting on Friday, April 27. He will address the RUC and provide an update on the AMA's activities involving the SMS. *See Other Business for discussion of Doctor Lewers presentation.*

- RUC members and their alternates were invited to attend a reception at the home of Jim Rodgers on Saturday, April 28.

- Two specialty societies have recently joined the RUC's Advisory Committee. The Society of Transplant Surgeons and the American Society of Breast Surgeons have appointed Advisors to participate in the RUC Process.

- Due to the size of the agenda at this meeting, Doctor Hoehn announced that he will limit discussion to two minutes per individual.

- Doctor Hoehn thanked each of the departing members of the RUC and provided each with a gift as a small token of appreciation for the significant volunteer work on behalf of organized medicine. The following individuals are departing from the RUC and were given the opportunity to make remarks regarding their experience with the Process:

Robert Florin, MD	American Association of Neurological Surgeons
David Massanari, MD	American Academy of Family Physicians
James Moorefield, MD	American College of Radiology
Alan Plummer, MD	American Thoracic Society/American College of Chest Physicians
David Regan, MD	American Society of Clinical Oncology
Paul Schnur, MD	American Society of Plastic Surgeons
Robert Zwolak, MD	Society for Vascular Surgery

- Ms. Celeste Kirschner was honored for her service to the CPT, RUC, and organized medicine.

Doctor Hoehn announced the following Facilitation Committees:

Facilitation Committee 1
William Rich, MD (Chair)
John Gage, MD
Alex Hannenberg, MD
Charles Koopman, MD
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
David Massanarri, MD
Alan Plummer, MD
SheldonTaubman, MD

Facilitation Committee 2
Paul Schnur, MD (Chair)
James Blankenship, MD
Joel Bradley, MD
William Gee, MD
Bernard Pfeifer, MD
David Regan, MD
Chester Schmidt, MD
Robert Zwolak, MD

Facilitation Committee 3
James Hayes, MD (Chair)
John Derr, MD
Robert Florin, MD
David Hitzeman, DO
David McCaffree, MD
John Mayer, MD
Bruce Sigsbee, MD
Don Williamson, OD

Facilitation Committee 4
Peter Sawchuk, MD, Chair
James Blankenship, MD
Thomas Felger, MD
Charles Mabry, MD
Barbara Levy, MD
Robert Zwolak, MD

Facilitation Committee 5
David McCaffree, MD
Joel Bradley, MD
Thomas Felger, MD
Barbara Levy, MD
Peter Sawchuk, MD
Trexler Topping, MD

Facilitation Committee 6
Alan Plummer, Chair
John Gage, MD
Gary Gramm, DO
Chester Schmidt, MD
Paul Schnur, MD

III. **Director's Report**

- Sherry Smith noted that an updated Calendar of Meeting Dates is located in Tab 2 of the agenda materials. The next scheduled RUC meeting is September 13-16, 2001 to be convened at the Swissotel in Chicago, Illinois.

- Patrick Gallagher informed the RUC that invitations for the celebration of the ten-year anniversary of the RUC will be mailed in June to all RUC participants and former RUC members.

- CD-ROMs were distributed at the RUC meeting. Ms. Smith clarified that the physician time data were refined in the database to included revisions for CPT 2001 coding changes, the Five-Year Review data, and refinements resulting from the Practice Expense Subcommittee review. *A revised CD-ROM was mailed to each RUC participant in June.*

- Ms. Smith announced that the AMA Board of Trustees had re-appointed Doctor Hoehn for a third, two-year term as Chair of the RUC.

IV. **Approval of Minutes for the February 1-3, 2001 RUC Meeting**

The minutes of the February 1-3, 2001 RUC meeting were approved with the following revisions:

Page 3:

- ~~Emergency~~ Emerging technology (CPT Category III codes)

- Improved description, enhanced specificity, and elimination of ambiguity

Page 20:

1. Primarily, the Committee questioned if the surgical codes selected for each anesthesia code are truly representative of all surgical codes associated with each of the 19 anesthesia codes. Given the methodology, it is necessary that the ~~surgical~~ ASA code be representative of the family of surgical codes.

V. CPT Update

Doctor Lee Eisenberg provided the RUC with an update regarding the upcoming May 2001 CPT Editorial Panel meeting. Doctor Eisenberg noted that a workgroup had been formed to review Excision of Lesions and this workgroup will begin meeting in May.

VI. HCFA Update

- Paul Rudolf, MD informed the RUC that the Proposed Rule on the Five-Year Review of the RBRVS is expected to be published in May. This Rule will discuss HCFA's decision regarding the RUC's recommendations submitted in October 2000 and February 2001 for codes in the Five-Year Review. The Rule will also address the issue of critical care in the global period. Doctor Rudolf noted that this discussion is generic in nature and no specific proposals regarding critical care are included in the Proposed Rule. *See discussion of Critical Care in the Other Business section at the conclusion of these minutes.*

- The Proposed Rule on the 2002 Physician Payment Schedule is expected to be published in June.

- Doctor Rudolf explained that the clinical examples for the Evaluation and Management guidelines will be sent to the specialty societies in May to review. He expects that pilot tests on the Evaluation and Management guidelines will begin in September or October.

- Doctor Rudolf also provided the RUC with an update on the physician time and length of stay studies that their contractors continue to review. He noted that HCFA will share these reports and studies with the RUC when they are completed. It is expected that the Health Economics Research (HER) report on changes to length of stay will be ready to share with the RUC at the September RUC meeting. Doctor Rudolf clarified that HCFA's intentions are to potentially use this data in the practice expense methodology and share the data with the RUC to determine if the changes in time and length of stay translate into a change in the work relative values for these codes.

- Carolyn Mullen explained that HCFA intends to propose re-pricing of clinical staff wages, medical supplies, and equipment. However, only the wage information will be included in the Payment Schedule Proposed Rule this

summer. HCFA will need to do further review and analysis prior to publishing any changes to the medical supplies and equipment pricing. RUC members voiced their concern regarding the accuracy of the pricing data for medical supplies and equipment. It was noted that specialties must rely on manufacturers for this information and there is no way to validate if these prices are correct. It was noted that specialties should be held harmless in this process and that the AMA's General Counsel's Office should review this issue. *Staff Note: The AMA has reviewed this issue with legal counsel and has included the following disclaimer with the RUC's recommendation:*

> *Cost estimates for medical supplies and equipment not listed on "HCFA's Labor, Supply and Equipment List for the Year 2001" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect wholesale prices, quantity or cash discounts, prices for used equipment or any other factors which may alter the cost estimates*

Ms. Mullen indicated that HCFA staff would also seek the advice of their legal counsel on this issue.

VII. **Washington Update**

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

- Patient Bill of Rights - there is general agreement on most of the patient protection elements, however, liability continues to be a major stumbling block. The AMA currently supports the McCain Bill.

- President's Budget - On April 9, President Bush submitted his budget. It mentions Medicare reform, however there is not likely to be any action on this issue this year, as some speculate that the Hill will wait to see what how the new HCFA Administrator, Tom Scully, restructures HCFA. The budget includes $156 billion in grants to states to fund prescription programs; tax credits for the working poor to purchase health insurance; increases in funding to the National Institute for Health (NIH); and funding for patient safety projects. Unfortunately, the budget also includes a proposed $1.50 per claim user fee for paper and duplicate claims.

- The Bush Administration has proposed the creation of a new federal database on adverse events. It would be voluntary and de-identify those involved in these cases. The Agency for Health Care Research and Quality, HCFA, CDC, and FDA would be involved. This database would be on the Internet and available to the public.

- Ms. McIlrath discussed the AMA's three-pronged approach to Medicare regulatory relief:

  Modifications to Clinton Administration Proposals - The AMA is working to modify a number of regulations proposed by the Clinton Administration at the end of the President's term, including:

  Limited English proficiency (LEP): The AMA is working to have this un-funded federal mandate from the Department of HHS Office of Civil Rights and Office of Minority Health repealed.

  EMTALA reform: HCFA and the Judicial system continue to expand the original intent of EMTALA. The AMA is working on legislation to limit the scope of EMTALA.

  Privacy Regulation: The privacy regulation will be implemented in April 2003. It is expected that the patient consent and business associates components will be modified. The AMA will be seeking a two year delay in the implementation of this regulation.

  Physicians Regulatory Issues Team - HCFA identified 15 issues that could be addressed immediately, and the Practicing Physicians Advisory Committee (PPAC) selected five priority issues to begin reforming, including:

  1. Advanced Beneficiary Notice – creation of a new universal simplified form..
  2. Certificate of Medical Necessity – reduce complexity and number of forms to be completed.
  3. Require Medicare Carriers to cover pre-operative evaluations.
  4. Prevent denials of claims for cancer follow-up visits.
  5. Clarify lab coverage policy, glucose monitoring, and physician supervision.

  Medicare Education and Regulatory Fairness Act (MERFA) – The AMA is engaged in a legislative effort provide physicians with regulatory relief. This legislation would inject fairness into the audit (both pre-payment and post-payment) process and would focus on education and prevention of coding errors. Currently, this legislation has 108 co-sponsors in the House and 22 co-sponsors in the Senate.

Doctor Gee noted that the Medicare Explanation of Benefits (EOB) form still included language instructing patients to contact a Fraud hotline if they did not agree that the services listed had been provided. It was noted that this form should first instruct patients to discuss the issue with their physicians, as the patient may not understand coding or what services had actually been performed.

VIII. **Election of Rotating Seats**

Doctor Lichtenfeld noted that issues had developed regarding the nominations for the rotating seat elections, including:

- An internal medicine subspecialty had nominated an individual who is not board certified in internal medicine; and

- A recognized internal medicine subspecialty (Allergy and Immunology) has been classified to be eligible for the "any other" rotating seat, rather than the internal medicine rotating seats.

Doctor Lichtenfeld moved that the election be deferred until these issues were discussed. Although the RUC agreed that these issues merit discussion and that it is important to maintain the balance of specialty representation on the RUC, the RUC did not approve this motion as the current rules state that the RUC is electing the specialty, not the individual. The Administration Subcommittee will review this issue at the September 2001 RUC meeting.

A second motion was made to revise the ballots to specifically list the specialty, not the individual nominated by the specialty. The RUC did not approve this motion, but noted that RUC members should utilize the first page of the agenda tab (which listed the nominees and their specialty societies) when casting their ballots.

The nominations for the internal medicine rotating seats were as follows:

Gastroenterology	Joel V. Brill, MD
Rheumatology	Melvin C. Britton, MD
Endocrinology	A. Jay Cohen, MD
Geriatrics	Meghan Gerety, MD
Hematology	David Regan, MD

The RUC elected Rheumatology (Melvin C. Britton, MD) and Geriatrics (Meghan Gerety, MD) to the two internal medicine rotating seats. A lottery process was conducted to determine that Doctor Gerety will hold the three-year seat and Doctor Britton will hold the two-year seat.

The nominations for the "any other" rotating seats were as follows:

Allergy and Immunology	Daniel Ein, MD
Sleep Medicine	Sam A. Fleishman, MD
Long Term Care	Kevin C. Fleming, MD
Dentistry	Lanny Garvar, DMD
Cataract and Refractive Surgery	Stephen Lane, MD
Critical Care Medicine	William T. Peruzzi, MD

Cardiovascular & Interventional Radiology	Robert Vogelzang, MD
Radiation Oncology	Paul Wallner, DO

The RUC elected Radiation Oncology (Paul Wallner, DO) to the "any other" rotating seat.

IX. **Conscious Sedation Request for Reconsideration**

An ad hoc committee (Doctors Hoehn, Bradley, Hayes, Levy, Mayer, and Schnur) convened to consider a request from the societies representing gastroenterology for reconsideration of the RUC's recommendation on conscious sedation. The committee recommends that the RUC re-consider this issue. Doctor Paul Schnur, Chair of the previous Conscious Sedation workgroup, also requested reconsideration as he was concerned with the process used to review this issue. He noted that any future workgroup meetings should be expanded to include all interested specialties.

The RUC considered two motions for this issue:

1. **The RUC will review the global issue of conscious sedation as it applies to all specialties.**

The RUC extensively discussed this issue. The RUC agreed that this was a complex issue that will be difficult to address as many codes inherently include conscious sedation. An e-mail discussion with Dan Dunn, PhD, included in the agenda materials, indicated that the Harvard researchers assumed that the physician work related to conscious sedation would be included in the work relative values for those procedures where it is an inherent component of the service. An exception was made for Dentistry, as a dental code for conscious sedation was available and in use at that time.

The RUC agreed that a decision will first need to be made regarding whether conscious sedation should be included within the work relative value of the procedure code or whether this work should be carved out and separately reported. It will also be necessary for each specialty to identify which services may require conscious sedation.

The RUC approved this motion and agreed to establish a workgroup to develop a long-term solution to this issue. Doctor Hoehn suggested that any specialty that is interested in participating in this workgroup contact himself or Ms. Smith.

2. **A second motion to reconsider specific increases to the physician work of gastrointestinal endoscopy services as it relates to conscious sedation was not approved.**

After discussion regarding the process utilized to review this issue at the February 2001 RUC meeting, staff clarified that the RUC had voted to not accept the work relative value recommendations of the conscious sedation workgroup. A facilitation committee was formed to review the ballots. More than two-thirds of the RUC members had indicated a zero work relative value. The facilitation committee recommended a work RVU of zero and the RUC adopted this recommendation. The RUC did not believe that it was appropriate to reconsider this action or to address this issue specific to gastroenterology at this time. The RUC agreed that the global issue must be first addressed before a resolution may be applied to any individual specialty.

X. **Relative Value Recommendations for *CPT 2001:***

Photodynamic Therapy (Tab 7)
Presenters: Joel Brill, MD, American Gastroenterological Association

As discussed in a letter presented by the specialty society, no further data has been provided for codes 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)* and 96571 *each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus).*

The RUC, therefore, considers its previous interim recommendation "unvalidated."

Magnetic Resonance Imaging (Tab 8)
Presenters: James Borgstede, MD and Steven E. Harms, MD, American College of Radiology

In May 2000, the RUC submitted the following recommendations for magnetic resonance imaging procedures:

> 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).

In April 2001, the RUC reviewed its previous recommendation and agreed that this issue involves "new technology" and should not have been subjected to work neutrality by HCFA. The RUC reviewed the other MRI codes and submits that relativity must be maintained in the individual families. MRI families for the orbit, face, neck, upper extremity, and lower extremity should all be valued consistently. MRI families for the chest, pelvis, and abdomen should be valued the same. The RUC agreed that the work relative values for the chest, pelvis, and abdomen families of MRI codes should be valued higher than the MRI families for the orbit face, neck, upper extremity and lower extremity.

Practice Expense:

The RUC does not recommend any refinements to the direct practice expense inputs, at this time, as the specialty did not present any practice expense data for these services.

XI. Relative Value Recommendations for *CPT 2002:*

Any Method/Technique/Approach (Tab 9)

The CPT Editorial Panel revised a number of codes that previous included the language "any method, technique, or approach" to better define these services. **The RUC agreed that these changes were editorial and did not change the physician work for these services.**

Radiology Revisions (Tab 10)
Presenter: James Borgstede, MD, American College of Radiology

The CPT Editorial Panel revised a number of radiology codes to better the services and to add appropriate cross-references following procedural codes to reference the appropriate imaging code to report if imaging guidance is performed. **The RUC agreed that these changes were editorial and did not reflect a change in physician work.**

The RUC did note a few typographical errors and asked that CPT reconsider the cross-reference following code 23350. *Staff Note: In May 2001, the CPT Editorial Panel revised the cross-reference under CPT code 23350 as follows:*

23350 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

(For radiographic arthrography radiological supervision and interpretation, use 73040. Flouroscopy (76003) is considered part of radiographic arthrography)

(When fluoroscopic guide injection is performed for enhanced CPT arthrography, use code 23350, 76003, and 73201 or 73202)

(When flouroscopic guided injection is performed for enhanced MR arthrography, use code 23350, 76003, and 73222 or 73223)

Ocular Photdynamic Therapy (Tab 11)
Presenter: Trexler Topping, MD, American Academy of Ophthalmology

The RUC will not submit recommendations on this issue at this time. The RUC is interested in reviewing this issue in two or three years, once the technology has become more widespread.

Revised Hemodialysis Access Flow Measurement (Tab 12)

In May 2000, the RUC submitted direct practice expense inputs for CPT code 90940. HCFA did not mention these recommendations in the *Final Rule* for the 2001 Physician Payment Schedule, however, HCFA indicated that 90940 would be bundled into the monthly capitated payment for dialysis services. The specialty societies assumed that HCFA would treat new code 90939 in a similar fashion and, therefore, did not present recommendations to the RUC. The RUC requests that HCFA consider how these decisions may affect private payors who also use the RBRVS. As we have argued in the past, HCFA should publish relative values for services, regardless of HCFA's coverage policies, so that other payors may utilize this information.

Anesthesia for Gastric Restrictive Procedure for Morbid Obesity (Tab 13)
Presenter: Karl E. Becker, American Society of Anesthesiologists

A new CPT code 00797 *Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity* was developed to describe anesthesia for gastric restrictive procedures for morbid obesity.

The RUC examined the survey results, which supported a base unit value greater than the reference service 00790 *Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified* (base unit value = 7). The RUC discussed the increased complexity involved in this code such as the increased work of positioning the patient, maintaining the airway and maintaining cardiovascular ventilation. Due to the increased difficulty of providing anesthesia to this type of patient with a number of health problems, the RUC agreed that an increase of 2 base units over the reference service is warranted. Since Anesthesia base units include practice expense as well as work recommendations, a separate practice expense recommendation does not apply for this code.

The RUC recommends a base unit of 9.00 for CPT code 00797.

Anesthesia for Interventional Radiology Procedures (Tab 14)
Presenter: Karl E. Becker, MD, American Society of Anesthesiologists

To redefine anesthesia for interventional radiology, eight new codes were created along with the revision of one code and the deletion of nine codes. In each instance the RUC examined the survey results but also placed additional emphasis on examining the rank order of codes within the family of interventional radiology anesthesia procedures. This was necessary since the ASA base units can not be examined in exactly the same way as physician work relative values.

01905 (EE 1)
The RUC examined the survey results for CPT code 01905 *Anesthesia for myelography, discography, vertebroplasty* in comparison to the reference code 01906 *Anesthesia for injection procedure for myelography; lumbar*. The RUC agreed that the new code was sufficiently similar to the reference code, which is being deleted, that the new code should be valued the same at 5 base units.

The RUC recommends a base unit of 5 for CPT code 0190X5

01916 (EE 2)
The RUC agreed with the ASA recommendation to crosswalk the value from the reference code 01918 *Anesthesia for arteriograms, needle; retrograde, brachial or femoral* (base unit =5) to the new code 01916 *Anesthesia for diagnostic arteriography/venography.* The RUC agreed that the two codes should be valued

the same since the reference code was previously used to report this procedure and due to the survey results that support equivalent base units between the two codes.

The RUC recommends a base unit of 5 for CPT code 01916

01924 (EE 3)

Although the anesthesia survey results recommended a base unit of 7 for CPT code 01924 *Anesthesia for therapeutic intervention radiologic procedures involving the arterial system; not otherwise specified,* the RUC concluded that the value of the code should be two base units less than the reference service CPT code 01920 *Anesthesia for cardiac catheterization including coronary arteriography and ventriculography (not to include Swan-Ganz catheter) (Base unit = 7)* in order to preserve proper rank order within the family of codes.

The RUC recommends a base unit of 5 for CPT code 01924

019294 (EE 4)
019295 (EE 5)

Codes 01925 Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; carotid or coronary, and code 01926 *Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic*, were examined together. The patient population for these codes has significant comorbidities that complicates the anesthesia work. Since 01925 is currently billed as code 01920 *Anesthesia for cardiac catheterization including coronary arteriography and ventriculography (not to include Swan-Ganz catheter*) (Base unit = 7), the RUC concluded that a straight crosswalk would be appropriate and would maintain proper rank order with the family. Code 01926 was examined in relation to 01925 and the additional work for providing anesthesia when considering the physiological consequences of occluding the aorta or cardiac chamber and placing a multi-piece stent. The RUC concluded that a one base unit increment above 01925 reflected the incremental work between these two codes.

The RUC recommends a base unit of 7 for CPT code 01925. The RUC recommends a base unit of 8 for CPT code 01926.

01930 (EE6)

The RUC agreed with the ASA recommendation to crosswalk the value from the reference code 01918 *Anesthesia for arteriograms, needle; retrograde, brachial or femoral* (base unit =5) to the new code 01930 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified.* The RUC agreed that the two codes should be valued the same since the ASA survey median value of 5 base units was the same as the value for the reference service. **The RUC recommends a base unit of 5 for CPT code 01930.**

01931 (EE7)

The RUC agreed with the ASA recommendation to crosswalk the value from the reference code 00790 *Anesthesia for intraperitoneal procedures in upper abdomen, including laparoscopy; not otherwise specified* (base unit =7) to the new code 01931 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (eg, Transcutaneous Porto-Caval Shunt (TIPS)*. The typical patient is usually unstable and there are often problems relating to venous access. The RUC agreed that the two codes should be valued the same since the reference code was previously used to report this procedure, and due to the survey results that support equivalent base units between the two codes.

The RUC recommends a base unit of 7 for CPT code 01931.

01932 (EE8)

The RUC examined code 01932 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular* to the reference code 00534 *Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator* (base unit = 7). This was described as an uncommon procedure and although the ASA recommended that the work between the two procedures was similar, the RUC felt that a base unit of 6 would more appropriately place this code in the proper rank order within the family of codes.

The RUC recommends a base unit of 6 for CPT code 01932.

01933 (EE9)

The RUC examined code 01933 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial* to the reference code 00214 *Anesthesia for intracranial procedures; burr holes, including ventriculography* (base unit = 9) as well as code 01932 *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation, intrathoracic or jugular* (recommended base unit 6). Although the ASA recommended a median base unit value of 8, the RUC concluded that the work involved in this procedure was slightly lower and that a base unit of 7 would be more appropriate and place the code in the proper rank order, especially in relation to code 01932.

The RUC recommends a base unit of 7 for CPT code 01933.

Anesthesia for Obstetrical and Reproductive Procedures (Tab 15)
Presenter: Karl E. Becker, MD, American Society of Anesthesiologists
Reviewed by Facilitation Committee 1

Ten new codes were added to CPT to redefine anesthesia for obstetrical and non-obstetrical procedures. This also included the deletion of five codes. In each instance the RUC examined the survey results but also placed additional emphasis on examining the rank order of codes within the family of interventional radiology anesthesia procedures. This was necessary since the ASA base units can not be examined in exactly the same way as physician work relative values.

00851 (FF1)
The RUC examined the survey results for code 00851 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection* in comparison to the reference code 00840 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not other specified* (base unit = 6). The RUC agreed that the skill and anesthesia risk for these codes was similar and therefore should have the same base units. Additionally, code 00851 was previously reported using the reference code 00840.

The RUC recommends a base unit of 6 for CPT code 00851.

00869 (FF 2)
The RUC agreed with the ASA recommendation of 3 base units, which was also the median survey value for code 00869 *Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; vasectomy, unilateral/bilateral.* This code was valued in relation to code *00920 Anesthesia for procedures on male genitalia (including open male urethral procedures); not otherwise specified* (base unit = 3) and was felt to be the most valid comparison since both codes involved similar work. Therefore, the RUC concluded that the work involved in both codes was the same and should have the same base units.

The RUC recommends a base unit of 3 for CPT code 00869.

01960 (FF3)

Code 01960 Anesthesia for vaginal delivery only *essentially replace code 00946* Anesthesia for vaginal procedures (including biopsy *of labia, vagina, cervix or endometrium); vaginal delivery* (base unit = 5), which is the code previously used to report this service. The RUC felt that a base unit of 5 was appropriate for anesthesia for vaginal delivery as described by this code where an epidural was not previously in place. Although the median survey value was 7 base units the RUC concluded that the vignette may have been atypical in that it described a breech delivery while more typically an epidural anesthetic is used for an uncomplicated vaginal delivery.

The RUC recommends a base unit of 5 for CPT code 01960.

01961 (FF4)

Code 01961 *Anesthesia for cesarean delivery only* replaces code 00850 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean section* (base unit = 7). This code describes the provision of anesthesia for a cesarean delivery where no other anesthesia had been used previously. Therefore the RUC agreed to crosswalk the base unit value of 7 to the new code. Also, this value was appropriate in comparison to the previous code for vaginal delivery since the increment of 2 base units reflected the additional work involved in a cesarean section.

The RUC recommends a base unit of 7 for CPT code 01961.

01962 (FF5)

Code 01962 *Anesthesia for urgent hysterectomy following delivery* is a stand alone code that was compared to reference code 00850 *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; cesarean section* (base unit = 7). The ASA recommended a base unit of 8 to reflect the complications involved in this type of case as compared to a cesarean section or hysterectomy. This code covers the provision of anesthesia for an urgent hysterectomy following delivery where up until this pint the anesthesiologist had not been involved. Therefore, this is a stand alone code. The RUC agreed that this value of 8 base units would place the code in proper rank order within the family.

The RUC recommends a base unit of 8 for CPT code 01962.

01963 (FF6)

Code 01963 *Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care* describes an urgent cesarean section where severe blood loss occurs and a hysterectomy is required. The median survey results of 9 base units was based on the higher intensity for the new code in comparison to reference code 00855 *Anesthesia for intraperittoneal procedures in lower abdomen including laparoscopy; cesarean hysterectomy* (base unit = 8). However, after discussing the code and the work involved the RUC concluded that the anesthesia work was sufficiently similar to the reference code especially since the reference code was previously used to report this service. The RUC concluded that a base unit of 8 would properly place this code in the correct rank order with this family of codes.

The RUC recommends a base unit of 8 for CPT code 01963.

01967 (FF7)

Code 01967 *Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)* is essentially the same as the reference code 00955 *Neruoaxial analgesia/anesthesia for labor ending in a vaginal delivery (includes any repeat subarachnoid needle placement and drug injection ad/or any necessary replacement of an epidural catheter during labor)* (base unit = 5) the RUC therefore agreed with applying the same value to the new code since it was previously used to report this procedure.

The RUC recommends a base unit of 5 for CPT code 01967

01968 (FF8)

The new code 01968 *Cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure)* describes a situation where code 01305 *Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)* (recommended base unit = 5) is billed for a planned vaginal delivery, but when an unplanned cesarean section occurs, the new add on code 01968 is also billed. The RUC agreed with the ASA recommendation of 3 base units. This reflects the additional intensity and work involved in changing anesthetic techniques in the middle of the delivery that represents the work involved in changing from vaginal delivery to cesarean section.

The RUC recommends a base unit of 3 for CPT code 01968.

01969 (FF9)

Code 01969 *Cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure)* describes a situation where the patient previously has a cesarean section but is currently undergoing vaginal delivery, but the vaginal delivery is unsuccessful due to fetal distress and therefore an urgent cesarean section occurs. During the cesarean delivery, the obstetrical discovers a tear in the mother's uterus through the previous cesarean scar. The ruptured uterus resulted in uncontrolled bleeding and an emergency hysterectomy was performed. Code 01305 *Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)* (recommended base unit = 5) accounts for the anesthesia work during the planned vaginal delivery such as the epidural. The new add on code 01969 then describes the work involved in providing anesthesia for the urgent cesarean delivery and also for the hysterectomy. The presenters stated that this code would be rarely used and the anesthesia work involves switching from an epidural to general anesthetic with significant blood loss, requiring an urgent hysterectomy. The RUC agreed that the work involved with a cesarean section and hysterectomy is significant and the

recommended value of 5 base units correctly places the code within the proper rank order.

The RUC recommends a base unit of 5 for CPT code 01969.

01964 (FF10)

Code 01964 *Anesthesia for abortion procedures* is rarely used and was created at the request of CPT. The ASA recommended a value of 4 based on a comparison to reference code 00946 *Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal delivery (base unit=5).*

The RUC recommends a base unit of 4 for CPT code 01964

Nonbiogradeable Androgen Suppression Implant (Tab 16)

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

Three new codes were developed specifically to describe services for the insertion and removal of non-biodegradable drug delivery implants that were not specific to a type of drug or a particular treatment. 11981 *Insertion, non-biodegradable drug delivery implant,* 11982 *Removal, non-biodegradable drug delivery implant,* and 11983 *Removal with reinsertion, non-biogradable drug delivery implant.*

The RUC agreed with the specialty's recommendation that these three new codes have similar physician work as codes: 11975 *Insertion, implantable contraceptive capsules*(work relative value = 1.48); 11976 *Removal, implantable contraceptive capsules* (work relative value=1.78); and 11977 *Removal with reinsertion, implantable contraceptive capsules* (work relative value=3.30) The RUC therefore crosswalked, codes 11975, 11976, and 11977 to codes 11981, 11982, and 11983. The RUC agreed to recommend these values on an interim basis until the specialty returns with survey data.

The RUC recommends work values for CPT codes 11981, 11982, and 11983 of 1.48, 1.78, and 3.30 respectively.

Practice Expense

The RUC recommended that the practice expense for codes 11975, 11976, and 11977 be applied to 11981, 11982, and 11983 respectively.

Cystoscopy / Cystourethroscopy Procedures (Tab 17)

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

Code 52001 *Cystourethroscopy with irrigation and evacuation of clots* was developed to capture the work and time involved in irrigating the clots and

decompressing the bladder, while code 52347 *Cystourethroscopy with transurethral resection or incision of ejaculatory ducts* was developed to record the transurethral resection or incision of ejaculatory ducts.

The RUC reviewed the specialty society's survey and consensus panel results, and concluded that the specialty recommendations for both codes seemed reasonable considering the physician work and time required.

52001 ***Cystourethroscopy with irrigation and evacuation of clots (Do not report with code 52000)***

The RUC believed the specialty society's survey responses from 56 practicing urologists tightly clustered in on the recommended median value. The RUC also believed reference code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or urethral stent from urethra or bladder (separate procedure); complicated* (work relative value of 5.21), represented similar physician work and complexity.

The RUC recommended a work relative value of 5.45 for CPT code 52001.

Practice Expense

The RUC recommended 4 minutes of clinical labor staff time for the completion of pre-service diagnostic & referral forms in the out of office setting. The direct practice expense inputs are included in a recommendation form. These services are only performed in a facility setting.

52347 ***Cystourethroscopy with transurethral resection or incision of ejaculatory ducts***

The RUC recognized that the mixed-panel/random sample of 73 practicing urologists overvalued the code and that a lower value was more appropriate. The physician time of reference code 52277 *Cystourethroscopy, with resection of external sphincter (sphincterotomy)* (work relative value of 6.17), was significantly higher than the surveyed median time, and a more complex, and intense procedure. The specialty society's panel of urologists came to same conclusion as the RUC and recommended the 25th percentile of their survey results rather than their median value. In addition the RUC believed the physician time for this new code should be recorded as the median surveyed time and not the 25th percentile physician time.

The RUC recommended a relative work value of 5.28 for CPT code 52347.

Practice Expense

The RUC recommended 4 minutes of clinical labor staff time for the completion of pre-service diagnostic & referral forms in the out of office setting for both codes. The direct practice expense inputs are included in a recommendation form. These services are only performed in a facility setting.

Insertion of Tandem Cuff (Tab 18)
Presenters: James B. Regan, MD and Jeffrey A Dann, MD, American Urological Association

A new CPT code 53444 *Insertion of tandem cuff (dual cuff)* has been created to provide more specificity in coding and to describe the insertion of a second cuff.

The RUC reviewed the survey data from 35 urologists and believed that the physician work involved in comparison to the reference codes; 53447 *Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff,* (work RVU = 13.17) and 53445 *Operation for correction of urinary incontinence with placement of inflatable urethral or bladder neck sphincter, including placement of pump and/or reservoir*(work RVU = 14.06) had similar intensity and complexity. The RUC believed that the surveyed physician time reflected the work, intra-operatively and in total for this new code, and was similar to the reference codes. The RUC considered the specialty society's survey median to a accurately represent the amount of work being performed.

The RUC recommends a work relative value of 13.40 for CPT code 53444.

Practice Expense
The RUC recommended the standard 090 global clinical labor practice expense package, a minimum visit supply package, a basic post operative incision care kit (with suture removal), and an exam table for the out of office setting for this service. There are no in office practice expense recommendations as this service is typically performed in the hospital.

Urethral Sphincter Procedures (Tab 19)
Presenters: James B. Regan, MD and Jeffrey A Dann, MD, American Urological Association
Reviewed by Facilitation Committee 1

New urethral sphincter procedure CPT codes were developed to better describe the exact nature of the appropriate surgical procedures related to the repair, removal, and/or replacement of inflatable sphincter devices.

53446 *Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff*

This new code was created to specifically describe the removal of the urethral/bladder neck sphincter, pump, reservoir, and cuff. The specialty society's surveyed median RVU = 13.17, is exactly the value of the reference code 53447 *Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff* (work RVU = 13.17). The RUC and the specialty society, however, believed that there was more physician time and work was being performed in the reference code, and that 53446 should have a lower work RVU.

The RUC also reviewed CPT code 53449 *Surgical correction of hydraulic abnormality of inflatable sphincter device* (work RVU = 9.70) compared to code 53446 in time and intensity, and concluded that the specialty's surveyed 25th percentile RVW correctly valued this new code.

The RUC recommends a work relative value of 10.23 for code 52446.

Practice Expense

The RUC agreed to the standard PEAC 090 day global clinical staff package for the out of office setting, 3 minimum visit supply packages, post-operative incision care kits (1 Suture, 1 Staple), and an exam table. The practice expense inputs are attached to this recommendation.

53447 ***Removal and replacement of inflatable Urethral/bladder neck sphincter including pump, resevoir, and cuff at the same operative session.***

The RUC reviewed the survey results and concluded that the recommended relative value of 14.08 was too high in comparison of similarly valued codes across specialties such as 32500 *Removal of lung, other than total pneumonectomy; wedge resection, single or multiple* (work relative value of 14.30). The RUC reviewed several similar procedures, and found that code 36830 *Creation of arteriovenious fistual by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft* (work RVU = 12.00) was similar in intra-service work. However, the RUC believed that there was additional work associated with the hospital visits and office visits with code 53447. Code 36830 did not require hospital visits, and includes only 1 office visit. Code 53447 was reported to have 1 hospital visit, a discharge day, and 3 office visits. The RUC also compared code 62143 *Replacement of bone flap or prosthetic plate of skull* (work relative value of 13.50) and code 42200 *Palatoplasty for cleft palate, soft and/or hard palate only* (work relative value of 12.00), as codes with similar or less physician work. This provided further evidence in supporting a value above 12.00 RVUs. Based on the belief that more physician time and effort was involved in code 53447 than in 36830, the committee recommended the 25th percentile survey value.

The RUC recommends a work relative value of 13.49 for CPT code 53447.

Practice Expense

The RUC agreed to the standard PEAC 090 day global clinical staff package for the out of office setting, 3 multi-specialty minimum supply packages, 2 post operative incision care kit (1 Suture, 1 Staple), and an exam table. The direct practice expense inputs are included in a recommendation form.

53448 ***Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue.***

The RUC reviewed the survey results and concluded that the recommended work relative value of 24.86 was too high in comparison to similarly valued codes across specialties. Specifically, the RUC questioned the incremental relative value difference between this code and code 53447.

The RUC reviewed the survey results again, and recognized that code 27091- *Removal of hip prosthesis; (separate procedure) complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer* (work relative value of 13.49) had similar work and intensity as code 53448. However, CPT code 27091 had less intra-service time and no hospital visits. The committee reviewed other orthopeadic codes and found that code 27091 could be used as an initial building block code. The committee then added the physician work of the post operative hospital visits involved, as well as 30 more minutes of intra-service time to come up with a value of 21.18 RVUs, which is similar to the 75th percentile of the survey. Based on these calculations, the RUC recommended the 75th percentile of 21.15 RVUs.

The RUC recommends a work relative value of 21.15 for CPT code 53448.

Practice Expense
The RUC agreed to the standard PEAC 090 day global clinical staff package for the out of office setting, 3 multi-specialty minimum visit supply packages, 2 post operative incision care kit (1 Suture, 1 Staple), and an exam table. The direct practice expense inputs are included in a recommendation form.

Transurethral Destr. of Prostate Water-induced Thermotherapy (Tab 20)
Presenters: James B. Regan, MD and Jeffrey A Dann, MD, American Urological Association
Reviewed by Facilitation Committee 1

A new CPT code 53853 *Transurethral destruction of prostate tissue; by water-induced thermotherapy* was developed to describe the new technology in the destruction of prostate tissue using water-induced thermotherpy.

The RUC reviewed the survey data from 45 urologist that perform the procedure and had some concerns about possible survey bias, as many or all of the survey respondents have used this particular device for the procedure. The intra-service time and intensity for this code in relation to its reference code 53850 *Transurethral destruction of prostate; by microwave thermotherapy* (work relative value = 9.45) and code 52310 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple* (work relative value = 2.81), could not support the specialty recommended

work RVU of 9.45. The RUC also reviewed several different codes across specialties and believed that code 54670, *Suture or repair of testicular injury* (work relative value = 6.41), could be used as an anchor code with similar physician work and time, with 30 minutes pre-service, 60 minutes intra-service, and 43 minutes post service time. The pre, post, and intra-service time provided the committee a crosswalk to 53853. In addition to the relativity to 54670 in time, the code's inter-operative work per unit of time was similar to 53853 as well.

In addition, when 53853 is compared to its reference code, 53850, the survey results show 30 minutes less of pre, intra, and post service time for the new code. The RUC then viewed the value of 53853 at 2/3 of the value of the reference code, resulting in a relative value of 6.44. The 2/3 of the reference code value provided the RUC with further support for the crosswalk to code 54670. The RUC believed that since the work of 54670 was similar to code 53853, the RUC recommends a value of 6.41 RVUs for code 53853.

The RUC recommends a work relative value of 6.41 for CPT code 53853.

Practice Expense
The direct practice expense inputs are included in a recommendation form. The practice expenses for CPT code 53853 were reviewed by the RUC and recommended that the following be excluded;
Tape
Gloves-non-sterile
30 cc syringe
10 cc syringe
Gloves - sterile

Penile Procedures (Tab 21)
Presenters: James B. Regan, MD and Jeffrey A Dann, MD, American Urological Association
Reviewed by Facilitation Committee 4

Three new CPT codes were created to provide more specificity to procedures involving penile plastic surgery. These codes were appropriately reported using unlisted code 55899 Unlisted procedure, urinary system. Also, code 54161 *Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn,* is a similar service, but would be inappropriate to use.

54162 ***Lysis or excision of penile post-circumcision adhesions***
The RUC reviewed the work of the reference code 54161 *Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn* (work RVU = 3.27), and believed the physician work was very similar, but took less slightly physician time and effort. The RUC thought that 25th percentile of the specialty's survey results correctly valued the code in this case. The RUC in addition, recommended to value this code identically to CPT code 54163 *Repair*

incomplete circumcision to prevent any adverse procedural selection between 54162 and 54163.

The RUC recommends a work relative value of 3.00 for CPT code 54162.

Practice Expense
The RUC recommends practice expense inputs for CPT code 54162 typically performed during an outpatient visit in the facility setting only, and are included in a recommendation form.

54163 ***Repair incomplete circumcision***
The RUC reviewed the work of the reference code 54161 *Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn* (work RVU = 3.27), and believed the physician work was very similar, but took slightly less physician time and effort. The RUC thought that the specialty society's median work RVU of 3.00 correctly valued the code, although the specialty had requested a higher work RVU. The RUC in addition, recommended to value this code identically to CPT code 54162 *Lysis or excision of penile post-circumcision adhesions*.

The RUC recommends a work relative value of 3.00 for CPT code 54163.

Practice Expense
The RUC recommends the following practice expense inputs for CPT code 54163 typically performed during an outpatient visit in the facility setting only, and are included in a recommendation form.

54164 ***Frenulotomy of the penis***
The RUC reviewed this new code in relation to its reference code 54001 *Slitting of prepuce, dorsal or lateral (separate procedure); except newborn* (work RVU = 2.19). The RUC believed that the work and intensity of the intra-operative work was similar to its reference code, but required more post-operative follow-up care. The RUC believed the that the specialty society's median survey results accurately valued this code.

The RUC recommends a work relative value of 2.50, for CPT codes 54164.

Practice Expense
The RUC recommends the following practice expense inputs for CPT code 54164 typically performed during an outpatient visit in the facility setting only, and are included in a recommendation form.

Penile Prosthesis (Tab 22)
Presenters: James B. Regan, MD and Jeffrey A Dann, MD, American Urological Association
Reviewed by Facilitation Committee 4

Seven new CPT codes were created, and three codes were deleted, to better describe the various surgical procedures involving penile prosthesis. Codes 54402 *Removal or replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis,* 54407 *Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders,* 54409 *Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump an/or reservoir and/pr cylinders,* were deleted at the request of the specialty society.

54405 ***Insertion, of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir*** **(For reduced services, report 54405 with modifier '-52')**

The RUC recommends no change in the work relative value for CPT code 54405 as there were only CPT editorial changes to the code descriptor, and no change in physician work.

The RUC recommends no change to the work relative value for CPT code 54405.

54415 ***Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis***

The RUC examined the survey results of 30 practicing urologists and believed that given the similarity of physician time and work effort in relation to the reference code 54400 *insertion of penile prosthesis; non-inflatable (semi-rigid)* (work RVU = 8.99), the median work RVU of 8.20 was appropriate. The RUC compared the new code's survey results of 50 minutes pre-service, 60 minutes intra-service, 30 minutes immediate post, and 3 follow up office visits, and believed the Harvard physician time for the reference code was quite similar. The Harvard physician time is slightly higher, indicating again that the relative value for this new code should be the survey median rather than closer to the reference code's work RVU.

The RUC recommends a work relative value of 8.20 for CPT code 54415.

Practice Expense
The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately in a recommendation form.

54416 ***Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session***

The RUC examined the survey results for this code and compared them to the reference CPT codes; 54407 *Removal, repair, or replacement of inflatable (mult-component) penile prosthesis, including pump and/or reservoir and/or cylinders* (work relative value of 13.34), and 54401 *Insertion of penile prosthesis; inflatable (self-contained)* (work relative value of 10.28). The RUC believed that the work effort for 54416 was less than code 54407 given the physician time, yet more physician time and effort than code 54401. The RUC supported the specialty society's recommended median survey results.

The RUC recommends a work relative value of 10.87 for CPT code 54416.

Practice Expense
The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately in a recommendation form.

54417 ***Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement***

The RUC reviewed the survey data presented by the specialty society and had difficulty accepting the specialty's proposed 75th percentile survey results for a work relative value. The RUC examined the work across specialties, noting that code 35907 *Excision of infected graft; abdomen* (work relative value of 19.24) had significantly more intra-service time than code 54417, and therefore it was inappropriate to value the code at the surveyed 75th percentile, and recommended the survey median. The RUC noted that the physician time for this code was quite similar in the pre and intra service periods to code 54407 *Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and /or reservoir and/or cylinders* (work RVU = 13.34), however, post operatively code 54417 included more hospital and office visit care. The RUC recognized that the specialty's median survey results represented the physician work involved.

The RUC recommends a relative work value for CPT code 54417 of 14.19.

Practice Expense
The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately in a recommendation form.

54406 ***Removal of all components of a multi-component ,inflatable penile prosthesis without replacement of prosthesis***

The RUC examined the survey results and gained an understanding the physician time and work effort in relation to reference code 54405 *Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir,*(work RVU = 13.43), code 54407 *Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders* (work RVU = 13.34), and the other codes in the family. In comparison to code 54406, the physician work effort and intensity of these reference codes were quite similar, however the post-operative care was less extensive. From this comparison, the RUC considered the specialty's survey median to be the appropriate work value.

The RUC recommends a work relative value of 12.10 for CPT code 54406.

Practice Expense
The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately in a recommendation form.

54408 ***Repair of component(s) of a multi-component, inflatable penile prosthesis***

The RUC had difficulty accepting the specialty's survey median work RVU of 13.30 since the work intensity required for the repair of the components was less difficult than the removal of all of the components of a multi-component inflatable penile prosthesis, represented by code54406. In addition, the RUC believed the post operative time was too high for such a procedure. The RUC recognized that this service had to be appropriately ranked within the other services already approved by the RUC. Code 54406 *Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis* was approved by the RUC at 12.10 RVWs. The services are similar except for 15 minutes additional intra-service time for 54408. After reviewing a number of different building block methodologies the committee felt that a relative value of 12.75 more appropriately reflected the work associated with this service, and placed the code in proper rank order within the family of codes.

The RUC recommends a work relative value of 12.75 for CPT code 54408.

Practice Expense
The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately in a recommendation form.

54410 ***Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session***

The RUC examined the survey results and believed that given the physician time and work effort, and in relation to CPT code 54406 *Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis*, (recommended work relative value of 12.10), code 54410 would be appropriately valued at the survey median. Inter-operatively, code 54410 resulted in 50 more minutes of physician time than 54406 with similar or greater intensity. The RUC recognized the greater intra-operative work involved in 54410 than 54406 and agreed with the median of the specialty's survey results.

The RUC recommends a work relative value of 15.50 for CPT code 54410.

Practice Expense
The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately in a recommendation form.

54411 **Removal and replacement of component(s) of a multi-component, inflatable penile prosthesis through an infected field an infected field at the same operative session including irrigation and debridement**

The RUC reviewed the survey results and compared the work code 54411 to other codes within its family. The specialty had initially recommended a value above the 75th percentile of their survey of 22.50, requesting a work RVU of 26.07, as they concluded that the respondents did not factor in the extensive post operative work involved with these patients. However, the RUC did not agree that the 75th percentile, or any value above the 75th percentile, accurately reflected the work of this code. The RUC compared the intra-operative time and intensity of this new code to code 50220 *Nephrectomy, including partial ureterectomy, any approach including rib resection;* (work RVU = 17.15), and believed the specialty's recommended 75th percentile work RVU of 22.50 was still too high. Based on the concern over the intra service time associated with the 75th percentile of the specialty's survey results, the RUC recommended the specialty society's median survey results.

The RUC recommends a work relative value of 16.00.

Practice Expense
The RUC utilized the standard direct practice expense input packages for 090 day procedures for this code, and all of the direct inputs listed separately in a recommendation form.

Implantation of Sacral Nerve Neurostimulators (Tab 23)
Presenters: James B. Regan, MD and Jeffrey A Dann, MD, American Urological Association
Reviewed by Facilitation Committee 4

One CPT code was editorially changed and two new CPT codes were created to reflect new technology for the implantation and incision for implantation of neurostimulators to control voiding dysfunction such as urge incontinence, urgency-frequency and nonobstructive retention.

64555 ***Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)***

The RUC recommends no change in the work relative value for CPT code 64555, as there were only CPT editorial changes to the code descriptor, and no change in physician work.

The RUC recommends no change to the work relative value for CPT code 64555.

64561 ***Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)***

The RUC reviewed the survey results for this code and had concerns about the difference between the specialty society's recommended work value and their reference code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* (work relative value of 6.74). The RUC noted that the reference code and the new code have similar intra-operative physician time and physician work. In addition the RUC noted and that the reference code's current value was close to the 25th percentile of the survey results (work RVU = 6.87). RUC representatives stated that the work of this new code was more in line with the reference code, and in order to avoid a rank order anomaly between the two codes, the RUC recommended the same work relative value as the reference code.

The RUC recommends a work relative value of 6.74 for CPT code 64561.

Practice Expense
The RUC reviewed the practice expense presented by the specialty society and found it to be appropriate for this 010 day global procedure. The RUC, however added an exam table to the in office medical equipment. The direct practice expense inputs are included in a recommendation form.

64581 ***Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)***

The RUC examined the code in comparison to similar codes such as the reference code 63655 *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* (work relative value 10.29) and 63407 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar*(work relative value 14.61), in regards to their intra-service work, and believed the work was similar. The RUC also gained an understanding of the work involved in the placement of electrodes through a scarred tract and re-performance of test stimulation to verify correct placement. This service essentially involves re-performance of 64561 *Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacralnerve)* (RUC recommended work RVU = 6.74) together with the placement of new, permanent electrodes, and not the reutilization of existing electrodes or existing tracts.

In addition, the RUC reviewed several zero day global services: 37205 (*Transcatheter occlusion or embolization*) with an RVW of 8.28, without survey data; 32606 (*Thoracoscopy, diagnostic with biopsy*) with an RVW of 8.40 and an intra-service time of 90 minutes, and 52345 (*Cystourethroscopy with uretheroscopy; with treatment of uretheropelvic stricture)* surveyed in 2000 with an intra-service time of 90 minutes and an 8.20 RVW. The committee felt that the work involved with these services inter-operatively, was similar to the work of 64581 (median = 120 minutes intra-service). The RUC utilized a building block approach, by first using the zero day global codes as anchor codes and adding the pre and post service time and intensity from the reference codes, the RUC was able to justify the specialty's survey median.

The RUC recommends a work relative value of 13.50 for CPT code 64581.

Practice Expense
The RUC reviewed the practice expense presented by the specialty society and found it to be appropriate for this 010 day global procedure. The RUC, however reduced the pre-service clinical labor time to 40 minutes from 60 minutes. The direct practice expense inputs are included in a recommendation form.

Therapeutic Injection for Carpal Tunnel and Tarsal Tunnel (Tab 24)
Presenters: Keith Brandt, MD, American Society of Plastic Surgeons and Ernie Found, MD, North American Spine Society

Code 20550 was revised and three additional codes created to describe injection of the carpal canal, tendon at origin or insertion, and trigger point. The RUC received a report supported by seven specialty societies representing orthopedic surgery, rheumatology, podiatry, plastic surgery, hand surgery, and spine surgery

pertaining to the following four codes: 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal canel; 20550 Injection, tendon sheath, ligament; ganglion cyst~~, or trigger points~~ ; 20551 Injection, tendon origin/insertion;* 20552 *Injection, single or multiple trigger point(s), one or more muscle group(s).* Due to the number of specialty societies involved, the specialties requested additional time to complete a survey and present a recommendation to the RUC. The specialties first had to identify the typical number of injections required and this differed by specialty. The RUC accepted an interim recommendation for these codes with the understanding that the specialty societies will present a recommendation at the September, 2001 RUC meeting. The RUC accepted the following interim recommendations:

The RUC recommends maintaining the current work RVU of 0.86 as an interim value for each of the four new/revised codes, keeping in mind that the survey data indicate one injection (unilateral) for 20526, 20550, and 20551, and two injections (unilateral) for 20552. The preliminary survey data suggest that there is not much difference in total work between the four codes as described (i.e., no compelling evidence to make changes). Even if slight work-RVU adjustments up or down could be determined for each of the four codes (relative to the current work RVU of 0.86), there is no way to determine the frequency distribution of typical patients, and, therefore, any effort at establishing family budget neutrality would be flawed. Establishing the codes in CPT 2002 and maintaining an interim work-RVU of 0.86 should result in near-term family budget neutrality (or even less than family budget neutral, taking into consideration the reporting restrictions being placed on 20552).

The RUC also recommends an interim total time of 20 minutes for 20526, 20550, and 20551, and an interim total time of 22 minutes for 20552, keeping in mind that the survey data indicate one injection (unilateral) for 20526, 20550, and 20551 and two injections (unilateral) for 20552.

Practice Expense
The RUC recommends that HCFA crosswalk the PEAC-approved practice expense data for 20550, with adjustments to supplies for one injection (20526, 20550, 20551) versus three injections (20552).

Hand/Finger/Wrist/Forearm/Musculoskeletal/Vascular/Nerve Proc. (Tab 25)
Presenter: Dan Nagle, MD, American Society for Surgery of the Hand
Reviewed by Facilitation Committee 1 (Pre-Facilitation)
Reviewed by Facilitation Committee 4 (25025 – JJ12 only)

Numerous revisions, additions and deletions were made to the hand surgery codes. These changes were made to add clarity to this section of CPT to allow more accurate coding and to reduce ambiguity. The RUC is submitting recommendations for 32 codes, two of these codes have interim recommendations.

GROUP 1
24343 (JJ5)
The total work for 24343 *Repair lateral collateral ligament, elbow, with local tissue* is equivalent to that of the reference code 27405 *Repair, primary, torn ligament and/or capsule, knee; collateral* (work RVU = 8.65) This was supported by the median survey value of 8.65 and a description that the work involved with this procedure on the elbow was similar to the reference code that involved the knee. The RUC agreed that five post-operative office visits was appropriate due to the need to meet frequently with the patient to evaluate the patient's progress with a range of motion program for the elbow. **The RUC recommends a work relative value of 8.65 for CPT code 24343.**

24344 (JJ6) and 24346 (JJ8)
The RUC assigned interim value recommendations to these two codes due to a lack of survey data. The specialty societies will collect survey data for these codes and present their results at the next RUC meeting. The work associated with code 24344 *Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft*) and code 24346 *Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)* is similar to the work associated with code 27428 *Ligamentous reconstruction (augmentation), knee; intra-articular (open)* (work RVU = 14.00). The knee and elbow ligament reconstructions have the following elements in common:

- Indicated for major joint instability
- Harvesting of a tendon graft
- Precise positioning and creation of periarticular bone tunnels
- Passage of tendon graft through bone tunnels
- Precise tensioning of the graft
- Close monitoring postoperative therapy
- Reconstruction of RCL (2434X4) and reconstruction of ACL both require an arthrotomy. Reconstruction of MCL (2434X2) is extra-articular, but an arthrotomy is routinely performed to assess the joint.
- Major neurovascular structures are at risk for both the knee and elbow reconstructions. The popliteal structures are at risk with the knee reconstruction, while the radial and ulnar nerves are at risk in the elbow reconstruction.

Survey data for 24343 and 24344 indicate that a work relative value of 8.65 is appropriate for these primary repairs. This value is the same as that assigned to code 27405 *Repair, primary, torn ligament and/or capsuel, knee; intra-articular (open)* (work RVU = 8.65). Since the increase in complexity inherent in the reconstruction of the collateral ligament of the elbow and knee is similar, the RUC recommends that 24344 and 24346 be given an interim RVW of 14.00 which is equal to the current work relative value for code 27428.

The RUC recommends an interim work relative value of 14.00 for CPT codes 24344 and 24346.

24345 (JJ7)

The total work for 24345 *Repair medial collateral ligament, elbow, with local tissue* is equivalent to reference code 27405 *Repair, primary, torn ligament and/or capsule, knee; collateral* (work RVU = 8.65). To place these code in proper rank order, the RUC agreed to accept the survey 25th percentile work RVU of 8.65 for 24345 instead of the survey median. The RUC agreed that five post-operative office visits were appropriate due to the need to meet frequently with the patient to evaluate the patient's progress.

The RUC recommends a work relative value of 8.65 for CPT code 24345.

GROUP 2

29900 (JJ30)

The work involved in code 29900 *Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy* is similar to the reference code 29840 *Arthroscopy, wrist, diagnostic, with or without synovial biopsy* (work RVU = 5.54) Although 29900 requires the creation of two portals as compared to four portals for 29840, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP joint, there is an increased risk of iatrogenic joint surface damage. The RUC recommends the survey median RVW of 5.42 for 29900 to reflect the slightly lower total work for 29900 compared with 29840.

The RUC recommends a work relative value of 5.42 for CPT code 29900.

29901 (JJ31)

The RUC compared 29901 *Arthroscopy, metacarpophalangeal joint, surgical; with debridement* to the reference service CPT code 29846 *Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement* (work RVU = 6.75) and concluded that the work involved in both procedures is similar. Although code 29901 requires the creation of two portals as compared to four for 29846, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP joint, there is an increased risk of iatrogenic joint surface damage. However, the work needed to debride the radio-carpal or ulno-carpal joint is greater than that needed to debride the smaller MCP joint. Additionally, the intra-operative work to debride an MCP joint is greater than the intra-operative needed to perform a diagnostic wrist arthroscopy and biopsy as described in 29840. Using the survey median value of 6.13 work RVUs for 29901 correctly estimates the relatively lower total work for 29901 compared with 29846 and the relatively higher work compared with 29840.

The RUC recommends a work relative value of 6.13 for CPT code 29901.

29902 (JJ32)

Total work for 29902 *Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stener lesion)* is only slightly less than the work for reference code 29846 *Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement.* Although code 29902 requires the creation of two portals as compared to four for 29846, the insertion of a small arthroscope and instruments into the MCP joint is more difficult given the small size of the MCP joint. Furthermore, because of the small size of the MCP joint, there is an increased risk of iatrogenic joint surface damage. The work of 29902 involves the debridement of the ulnar aspect of the thumb MCP joint followed by the identification and reduction of the displaced ulnar collateral ligament. This work is slightly less complex than the work of 29846 which involves debridement of radio-carpal joint, ulno-carpal joint or triangular fibrocartilage. Additionally, the work to debride the MCP joint requires more intra-operative work than 29840 *Arthroscopy, wrist, diagnostic, with or without synovial biopsy* (work RVU = 5.54) The survey median value of 6.70 correctly estimates the slightly lower total work for CPT code 29902 compared with CPT code 29846 and the higher work when compared with CPT code 29840.

The RUC recommends a work relative value of 6.70 for CPT code 29902.

GROUP 3

64821 (JJ33)

CPT code 64821 *Sympathectomy; radial artery* involves one artery, while the reference code 64820 *Sympathectomy, digital arteries, with magnification, each digit* (work RVU = 10.37) involves two arteries in each digit. There is 30 minutes less intra-operative time for code 64821 compared with the reference procedure code 64820, however, 64821 has more risk associated because damage to the radial artery may result in loss of several fingers. Therefore this procedure includes an overnight hospital stay for monitoring. Pre-service and post-service work are essentially the same for both procedures. Because the only difference is less intra-operative time (albeit slightly more intra-operative and postoperative intensity for 64821), both the survey median and the survey 25th percentile was judged by the specialty societies as too high relative to 64820. To develop a work RVU that would place this code in proper rank order, the RUC agreed to a work RVU of 8.75. This value was calculated by taking the estimated IWPUT of 0.054 for the reference code 64820 times 30 minutes (=1.62 RVWs) and subtracting this from the current value of 64820 (10.37-1.62=8.75).

The RUC recommends a work relative value of 8.75 for CPT code 64821.

64822 (JJ34)

CPT code 64822 *Sympathectomy; ulnar artery* involves one artery, while the reference code 64820 *Sympathectomy, digital arteries, with magnification, each digit* (work RVU = 10.37) involves two arteries in each digit. There is 30 minutes less intra-operative time for 64822 compared with 64820, however, 64822 has

more risk associated because damage to the ulnar artery may result in loss of several fingers. Pre-service and post-service work are essentially the same for both procedures. Therefore this procedure includes an overnight hospital stay for monitoring. Because the only difference is less intra-operative time (albeit slightly more intra-operative and postoperative intensity for 64822), both the survey median and the survey 25th percentile was judged by the specialty societies as too high relative to 64820. To develop a work RVU that would place this code in proper rank order, the RUC agreed to a work RVU of 8.75. This value was calculated by taking the estimated IWPUT of 0.054 for 64820 times 30 minutes (=1.62 RVWs) and subtracting this from the current value of 64820 (10.37-1.62=8.75). This would also be the same value as the recommendation for code 64821.

The RUC recommends a work relative value of 8.75 for CPT code 64822.

64823 (JJ35)

The RUC agreed that the work involved with CPT code 64823 is equivalent to the reference code 64820 *Sympathectomy, digital arteries, with magnification, each digit* (work RVU 10.37). Intra-operatively, 64823 *Sympathectomy; superficial palmar arch* involves the exposure of the superficial palmar arch as it traverses the palm. The operative approach exposes the arch, the adjacent common and proper digital nerves and arteries and the underlying flexor tendons. The reference code 64820 involves the exposure of the two digital neurovascular bundles and the two tendons of the involved finger. Pre-service and post-service work are essentially the same for both procedures. The RUC recommends the survey median of 10.37 for 64823 to appropriately set these codes' relative values relative to each other.

The RUC recommends a work relative value of 10.37 for CPT code 64823.

GROUP 4

25651 (JJ19)

Prior to the establishment of code 25651 *Percutaneous skeletal fixation of ulnar styloid fracture,* a CPT code to describe this procedure did not exist. The RUC concluded that the work for code 25651 is essentially equivalent to the reference code 26608 *Percutaneous skeletal fixation of metacarpal fracture, each bone* (work RVU = 5.36). Although there is no time and visit data for 26608, the survey respondents chose this code almost exclusively as the reference code, and the intensity/complexity measures validate the work equivalency. The RUC recommends the survey median RVW of 5.36 for 25651, which is equal to 26608.

The RUC recommends a work relative value of 5.36 for CPT code 25651.

25652 (JJ20)

The RUC compared code 25652 O*pen treatment of ulnar styloid fracture* to reference code 26665 *Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation* (work RVU = 7.60). Both procedures require an arthrotomy and mobilization of adjacent tendons and nerves. Both require the manipulation of small fracture fragments. A failure to repair the ulnar styloid fracture can lead to instability and arthrosis of the distal radio-ulnar joint while the failure to repair a Bennet fracture will lead to instability and arthrosis of the first CMC joint. The postoperative immobilization of a Bennet fracture includes a forearm based splint/cast while the postoperative immobilization of an ulnar styloid fracture requires a long arm splint/cast. The RUC agreed tat the work was similar for both codes and recommends the survey median 7.60 for 25652. This value is equal to code 26665 and greater than the recommended value of 5.36 for code 25651 *Percutaneous skeletal fixation of ulnar styloid fracture*.

The RUC recommends a work relative value of 7.60 for CPT code 25652.

25671 (JJ21)

The RUC compared CPT code 25671 *Percutaneous skeletal fixation of distal radioulnar dislocation* to the reference code 26706 *Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation* (work RVU = 5.12). Pre-operative evaluation for 25671 is more extensive than for 26706, as a distal radio-ulnar joint dislocation can be associated with injuries to the radius and/or ulna, the interosseous membrane, and the elbow joint. The percutaneous fixation of an MCP joint dislocation and a distal radio-ulnar joint dislocation are similar in that both place tendinous structures at risk. However, 25671 places the ulnar neurovascular bundle and its branches at risk, while 26706 is carried out through planes that are relatively free of significant neurovascular structures. The postoperative immobilization for 25671 includes a long arm splint/cast, while the postoperative immobilization for 26706 includes a hand based splint/cast. Therefore the RUC concluded that the survey median value of 6.00 for 25671 appropriately values the code greater that the reference procedure CPT code 27606, which involves less work.

The RUC recommends a work relative value of 6.00 for CPT code 25671.

GROUP 5

25024 (JJ11) and 25025 (JJ12)

These two fasciotomy codes were examined together to determine proper rank order. The RUC initially examined the differences between the reference procedures, one that included debridement and one that did not. Since the frequency for code 25020 *Decompression fasciotomy, forearm and/or wrist; flexor or extensor compartment* (work RVU = 5.92) is less than code 25023 *Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve* (work RVU = 12.96) the RUC was not concerned that there

might be an abuse of these codes when selecting between the code with debridement and the one without debridement. Code 25024 *Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve* requires more pre-service, intra-service, and post-service time and is intra-operatively and postoperatively more intense than 25020 (flexor OR extensor). Currently, it is possible to report 25999 (*unlisted*) or 25020-22 with 25020-51 for cases requiring decompression of both compartments, but this does not permit accurate tracking because 25020-51 may be secondary to another procedure. Also, using multiple procedure reporting does not account for the increased complexity of this patient (compared with a patient requiring 25020). The RUC agreed that the survey median value of 9.50 accurately accounted for the increased work involved in the typical patient requiring decompression of two compartments as compared with reference code 25020.

25025 *Decompression fasciotomy, forearm and/or wrist, flexor and extensor compartment; with debridement of nonviable muscle and/or nerve* requires more pre-service, intra-service, and post-service time and is intra-operatively and postoperatively more intense than the reference service code 25023 (flexor OR extensor). The RUC agreed that this procedure had more physician work that code 25024 due to the debridement, however, the RUC did not agree that the survey median of 18.48 reflected the increased work of debridement as compared to code 25024. The RUC attempted to determine a value for the debridement and reviewed codes 25020 *Decompression fasciotomy, forearm and /or wrist, flexor or extensor compartment; without debridement of nonviable muscle and/or nerve (*work RVU =5.92) and code 25023 *Decompression fasciotomy, forearm and/or wrist, flexor or extensor compartment with debridement of nonviable muscle and/or nerve* (work RVU= 12.96). This comparison resulted in a difference of 7.04 RVWs for the debridement of nonviable muscle and /or nerve. Applying this differential to the recommended value of 9.50 for code 25024 the RUC recommends a total RVW of 16.54. this value would then properly ranks both codes 25024 and 2525 by accounting for the additional work of debridement.

The RUC recommends a work relative value of 9.50 for CPT code 25024.
The RUC recommends a work relative value of 18.48 for CPT code 25025.

GROUP 6
25394 (JJ14)
CPT code 25394 *Osteoplasty, carpal bone, shortening* is an intra-articular procedure that demands accurate restoration of the capitate articular surface. This precision requires more intra-operative work than the reference code 28302 *Osteotomy; talus,* (work RVU = 9.55) which is extra-articular. Both procedures are carried out near neurovascular and tendinous structures that must be protected. Both procedures require internal fixation and cast immobilization. Both procedures require management and monitoring of postoperative therapy. The survey median of 10.40 is slightly higher than the value for reference code 28302

to account for the additional intra-operative work. **The RUC recommends a work relative value of 10.40 for CPT code 25394.**

25430 (JJ15)

The specialty societies recommended using the 25% value rather than the median value because the specialty society consensus committee reviewing the data for CPT code 25430 *Insertion of vascular pedicle into carpal bone (eg, Harii procedure)* believe the survey respondents overestimated the work relative value by comparing the work to CPT code 15740 *Flap; island pedicle* (work RVU = 10.25). Since code 15740 is "generic" in that the flap can be quite variable and the survey respondents to this survey were not offered the vignette that resulted in the value based on the original Harvard study, the specialty societies concluded that the respondents overestimated the value for code 25430. The RUC agreed that 25th percentile work relative value of 9.25 correctly places the procedure lower than code 15740.

The RUC recommends a work relative value of 9.25 for CPT code 25430.

GROUP 7

24332 (JJ4)

The total work for code 24332 *Tenolysis, triceps* is equivalent to the reference code 24305 *Tendon lengthening, upper arm or elbow, each tendon* (work RVU = 7.45). Both of these procedures require the isolation of a myotendinous unit and place important neurovascular structures at risk. Both procedures require the prescription and monitoring of postoperative therapy. While code 24305 includes the incision and lengthening of a tendon, 24332 includes the lysis of adhesion from around the triceps tendon and muscle. The survey median value of 7.45 is the same value as the reference code 24305 and correctly sets these two codes relative to each other.

The RUC recommends a work relative value of 7.45 for CPT code 24332.

25001 (JJ10)

The RUC agreed with the Specialty Society analysis, which concluded that the survey respondents overestimated the work RVU 25001 *Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis),* which requires a different approach than the reference code 25000 *Incision, extensor tendon sheath, wrist (eg, deQuervains disease),*(work RVU = 3.38), Although code 25001 requires a different approach, it represents the same total work as the reference code. This new code was created to complement the reference code and allow correct coding for the less frequently performed incision of "flexor" tendon sheath. The RUC therefore agrees that the survey 25th percentile RVW of 3.38 for 25001 is appropriate since it is the same value as code 25000.

The RUC recommends a work relative value of 3.38 for CPT code 25001.

25275 (JJ13)

The RUC compared code 25275 *Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)* to the reference code 25274 *Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), forearm and/or wrist, each tendon or muscle* (work RVU = 8.75). The RUC concluded that code 25275 is similar to the reference procedure but involves slightly less work. Although code 25275 requires slightly less intra-operative work than the reference code, code 25274 usually requires dissection of the injured tendon from scar as well as two tendinous anastomoses. The scaring at the sixth dorsal compartment associated with 25275 is usually mild and while the reconstruction of the tendon sheath must be precise, it is a bit less work than two tendinous anastomoses. Postoperative care for both procedures includes some form of immobilization and subsequent prescription and monitoring of therapy. The RUC recommends that the survey median value of 8.50 for 25275 correctly values the procedure in relation to code 25274.

The RUC recommends a work relative value of 8.50 for CPT code 25275.

29086 (JJ29)

29086 *Application, cast; finger (eg, contracture),* which includes fabrication of the case, is more total work than the reference code 29131 *Application of finger splint; dynamic* (work RVU = .55) as 29086 requires the application of casting material directly on the finger skin. This direct cutaneous contact carries more risk of cutaneous and neurovascular compromise than code 29131. This increased risk requires more pre and post service patient education and monitoring as reflected in the survey. Additionally, 29086 requires less time than 29075 therefore the Specialty Society recommended, and the RUC agreed that the survey 25th percentile value of 0.62 for 29086 is correct. This value is correctly placed between 29131 and 29075.

The RUC recommends a work relative value of .62 for CPT code 29086.

GROUP 8

24300 (JJ9)

Pre-service and intra-service work of code 24300 *Manipulation, elbow, under anesthesia* is similar to the reference code 23700 *Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)* (work RVU = 2.52). Code 24300 includes more postoperative work because it has been assigned a 90-day global period (compared with 23700, which has a 10-day global). Patients requiring 24300 will be seen weekly for the first four weeks and then at 6 weeks and 12 weeks. The RUC concluded that the survey median value of 3.75 for code 24300 is appropriate since it is higher than code 23700 to account for the additional post-operative work for five additional office visits

during the 90-day global. **The RUC recommends a work relative value of 3.75 for CPT code 24300.**

25259 (JJ18)

Pre-service and intra-service work of code 25259 *Manipulation, wrist, under anesthesia* is similar to 23700 *Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)* (work RVU = 2.52) and the previous code 24300 *Manipulation, elbow, under anesthesia* (recommended work RVU = 3.75). Code 25259 includes more postoperative work because it has been assigned a 90-day global period (compared with 23700, which has a 10-day global). Patients requiring 25259 will be seen weekly for the first four weeks and then at 6 weeks and 12 weeks. Total work for 25259 and 24300 is the same. The RUC concluded that the survey median value of 3.75 for code 25259 is appropriate since it is higher than code 23700 to account for the additional post-operative work for five additional office visits during the 90-day global.

The RUC recommends a work relative value of 3.75 for CPT code 25259.

26340 (JJ25)

Code 26340 *Manipulation, finger joint, under anesthesia, each joint* requires more pre-service time than reference code 26600 *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (work RVU = 1.96). Code 26340 will be used most often for post-traumatic contracture while code 26600 will be emergent and straightforward. The complications associated with manipulation of a finger joint include fracture, tendon rupture, skin laceration and neurovascular compromise. These complications are not associated with code 26600 and therefore the pre-service discussion with the patient is more complex with 26340 than with 26600. Additionally, the postop work for 26340 will be greater as the surgeon must carefully prescribe and closely monitor intensive postoperative therapy without which the procedure will fail. The treatment of an undisplaced metacarpal fracture requires far less vigilance. The RUC therefore concluded that the survey median value of 2.50 appropriately values the code in relation to 26600, and the slightly higher value accounts for the additional pre-service and post-service work.

The RUC recommends a work relative value of 2.50 for CPT code 26340.

GROUP 9

25431 (JJ16)

The total work for code 25431 *Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone* is equivalent to reference code 25440 *Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)* (work RVU = 10.44). Code 25431 was created to complement the nonunion repair of the scaphoid and allow correct coding for the

less frequently performed nonunion repair of the carpal bone. The RUC agreed that the survey median value of 10.44, which is the same as code 25440 is appropriate.

The RUC recommends a work relative value of 10.44 for CPT code 25431.

GROUP 10 Crosswalked values and editorial changes

25440 JJ17

Code 25440 *Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)* (work RVU = 10.44) did not undergo a CPT revision but the code was sent to the RUC due to a possibility that the value of the code was affected by the revisions and creation of new codes. The RUC concluded that the code was not affected and recommends no change in value since code 2095X1 was deleted and therefore eliminated any possible overlap with this code.

The RUC recommends a work relative value of 10.44, no change in work relative value for CPT code 25440.

26510 JJ22

CPT code 26510 *Cross intrinsic transfer, each tendon* (work RVU = 5.43) was surveyed during the Harvard study. Only intra-service time was surveyed and only three orthopedic surgeons provided information for the intra-time. The Harvard study report indicates that this code did not have a statistically significant response. The "vignette" for the survey of this code was "cross intrinsic transfer/thumb tendon transfer." The AMA CPT "short" descriptor for this code is "thumb tendon transfer." The orthopedic and plastic hand surgeons who use this code for reporting purposes believe that both the Harvard study and the CPT nomenclature never represented more than one tendon and this code is typically used to describe the transfer of one intrinsic tendon from one finger to the adjacent finger to limit ulnar drift.

The RUC recommends a work relative value of 5.43, no change in the work relative value for CPT code 26510 since the changes were deemed editorial and not a change in the service.

26587 JJ23

In 1992 and 1993, HCFA asked the RUC to recommend work-RVUs for carrier priced codes. Specialty societies surveyed many replantation and reconstruction codes and while both code 26585 *Repair bifid digit* (work RVU = 14.05) and code 26587 *Reconstruction of polydactylous digit, soft tissue and bone* were both surveyed, but the HCFA, RUC, and Society paper trail is not clear as to why only a recommendation for CPT 26585 proceeded to the RUC and why 26587 remained carrier priced. The specialty society proposed that code 26585 should be deleted since it is the same as 26587. Further, the term *supernumerary* is more correctly indicated as *polydactylous*. The CPT Editorial Panel accepted both of

these changes based on this rationale. With respect to valuing 26587, which until now has been carrier priced, the RUC recommends crosswalking the value from 26585. A review of the vignette and service description from the RUC summary for 26587 supports the recommendation that both codes represent the same operation and that crosswalking is appropriate.

The RUC recommends a work relative value of 14.05 for CPT code 26587.

26590 JJ24
Code 26590 *Repair macrodactylia, each digit* (work RVU = 17.96) has always referred to repair of one digit. The Harvard vignette was "repair macrodactylia/repair finger deformity," but the code was initially carrier priced. This code was reviewed by the specialty society and a recommendation was submitted to the RUC in 1994. The vignette used the intra-service description, and discussion at the RUC indicated that the value for this code is based on one digit.

The RUC recommends a work relative value of 17.96, no change in the work relative value for CPT code 26590 since the changes were deemed editorial and not a change in the service

26685 JJ26
Code 26685 *Open treatment of carpometacarpal dislocation, other than thumb ~~(Bennett fracture)~~ ; ~~single~~, with or without internal or external fixation, each joint,* (work RVU = 6.98) was judged by the RUC to be a straight forward editorial change. The nomenclature was revised to be consistent with CPT standards and "single" was changed to "each joint" and Bennett fracture was deleted because that fracture is specifically for a thumb only.

The RUC recommends a work relative value of 6.98, no change in the work relative value for CPT code 266685 since the changes were deemed editorial and not a change in the service

26843 JJ27 and **26844 JJ28**
Code 26843 *Arthrodesis, carpometacarpal joint, digit~~s~~ , other than thumb, each* (work RVU = 7.61) and code 26844 *Arthrodesis, carpometacarpal joint, digit~~s~~ , other than thumb, each with autograft (includes obtaining graft)* (work RVU = 8.73) underwent editorial changes. The "arthrodesis" procedure refers to the CMC "joint" and not to a digit (ie, an arthrodesis is performed on a joint, not a digit). It was poor grammar to indicate "digits" as plural when the arthrodesis was for one joint. For those surgeons who perform this operation, this code logically would never have been thought to include the work of arthrodesis of more than one CMC joint. Also, the Harvard vignette for this code was "'Arthrodesis of carpometacarpal digits, not thumb/fusion of hand joint". Admittedly, this too was poor language - but clearly included only one joint and one arthrodesis procedure. The AMA CPT short descriptor is "fusion of hand

joint" (ie, not plural). The addition of the word "each" was to clearly and unambiguously describe the procedure for those persons without a clear understanding of medical terminology.

The RUC recommends no change in the work relative value for CPT codes 26843 7.61, and 26844 8.73, since the changes were deemed editorial and not a change in the services.

Practice Expense
The RUC is recommending using the RUC approved practice expense standard packages for these codes. Only inputs for the facility setting is provided since these procedures are not performed in the office. Specifically, for all codes with 90 day global periods, the RUC is recommending 60 minutes of pre-service time, and the E/M clinical staff time for the number and level of post operative office visits included in the summary of recommendation form. Additionally, the staff blend of RN/LPN/MA is recommended. For medical supplies the RUC is recommending the standard minimum supply packages for each post operative office visit as well as one post operative incision care kit. The specific practice expense inputs are included in a summary of recommendation form. For code 29086, *Application, cast; finger (eg, contracture),* which has a 000 day global period, the RUC is recommending a crosswalk of RUC refined inputs from code 29075 *Application; elbow to finger (short arm).* The clinical staff time and other inputs are similar.

Closed Treatment of Metacarpal Fracture (Tab 26)
Presenters: Dan Nagle, MD, American Society for Surgery of the Hand and David Martin, MD, American Academy of Orthopaedic Surgeons

Code 26607 *Closed treatment of metacarpal fracture, with manipulation, with ~~internal or~~ external fixation, each bone* was revised to eliminate the inconsistency with describing a closed treatment that also includes internal fixation. Due to the editorial change it was noted that there may be a rank order anomaly in the family of codes since the percutaneous codes had work relative values greater than the open procedures. The RUC agreed with the specialty society recommendation to consider the change to 26607 editorial with the understanding that the specialty will bring the entire family of codes (26600, 26605, 26607, 26608, 26610, and 26615) back to CPT and the RUC to eliminate any rank order anomalies.

Hallux Valgus Repair (Tab 27)
Presenters: Tye J. Ouzounian, MD, American Academy of Orthopaedic Foot and Ankle Society
Reviewed by Facilitation Committee 2

The RUC reviewed code 28299 *Correction, hallux valgus (bunion), with or without sesamoidectomy, by ~~other methods (eg~~, double osteotomy~~)~~* during the

five-year review and recommended an increase from 8.88 work RVUs to 9.18 work RVUs. The RUC did not fully agree with the specialty society survey data at the time of the five-year review due to a concern that the CPT code descriptor should be changed to be consistent with the vignette, which described a double osteotomy. The RUC recommended that this issue be referred to CPT.

The CPT Editorial Panel reviewed this code and made revisions as suggested by the RUC. The specialty societies then presented their original work relative value and survey data during the April, 2001 RUC meeting.

The RUC concluded that the work relative value for code 28299 should reflect the work of 28296 *Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)* (work RVU = 9.18) plus an increment for the second osteotomy. The RUC developed its recommendation by calculating the work of the second osteotomy as follows:

28310	*Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)*	5.43

Less pre- and post-time:

99238 *Discharge Day Management*		1.28
99212 *Level 2 E/M Office Visit* (3 x .45)	1.35	
	2.63	
Intra-Service Work	2.80	
½ of Intra-Service Work (Incision already made)		1.40

28299 (9.18) + 1.40 = 10.58

The RUC recommends a work relative value of 10.58 for CPT code 28299.

Arthroscopic Shoulder Procedures (Tab 28)

Presenter: David Martin, MD and William Beach, MD, American Academy of Orthopaedic Surgeons, Arthroscopy Association of North American, and the American Shoulder and Elbow Surgeons

29806 II1

Code 29806 *Arthroscopy, shoulder, surgical, capsulorrhaphy* was created to allow physicians to code for shoulder stabilizations arthroscopically where previously this surgery was always an open procedure. In current practice, the pre-service and post-service "work" (time and intensity) for 29806 (laparoscopic capsulorrhaphy) and the reference code 23455 *Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)* (work RVU = 14.37) are essentially equivalent. Since the intra-service time for both procedures is similar, and the RUC concluded that the intensity between the two services was also similar,

although the specialty society contended that there is greater intensity and complexity for 29806. Given that the 25th percentile value of 14.37 equaled the value of the reference code, the RUC determined that this new code was equivalent in work to the reference code, which describes the open procedure.

The RUC recommends a work relative value of 14.37 for CPT code 29806.

29807 II2

Code 29807 *Arthroscopy, shoulder, surgical, repair of slap lesion* is similar to the previous code 298006 but involves less work. Code 29807 was also compared to the reference code 23455 *Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)* (work RVU = 14.37). Code 29807 requires less intra-operative time than 29806 because; 1) X3 generally requires the insertion of fewer soft tissue stabilization devices, 2) the tissue being stabilized does not need to be "shifted", and 3) the access to the area in question is less occupied by neurovascular structures. Due to the less maneuvering involved, 29807 should have a value slightly less than 29806. The RUC accepted the 25th percentile value of 13.90 as this value was slightly below the recommended value for 29806 and correctly placed the codes in proper rank order.

The RUC recommends a work relative value of 13.90 for CPT code 29807.

Practice Expense

Codes 29806 and 29807 are only performed in a facility setting, therefore, there are no proposed direct practice expense inputs for the office setting. The RUC recommends that the standard developed for the 090-day major surgical procedures be applied for this code.

Gait and Motion Studies (96005) (Tab 29)

Presenters: David Martin, MD, American Academy of Orthopaedic Surgeons and Jon Davids, MD, Gait and Clinical Movement Analysis Society

Reviewed by Facilitation Committee 6

The RUC discussed new CPT code 96004 and concluded that the vignette needed to be re-written to exclude physician work that would be captured in a separately reportable evaluation and management service and to specify the typical number of tests to be interpreted. The RUC also recommended that the specialty re-survey this service and work with the American Physical Therapy Association as they also prepare recommendations for the September 2001 meeting. The CPT Editorial Panel has also re-visited these codes at their May 2001 meeting and changed the introductory notes to clarify the use of the physician review and interpretation code 96004 so that the code is reported only once, regardless of the number of gait and motion tests performed. The RUC will place this issue on its September 2001 meeting agenda. In the event that HCFA is unable to utilize this

information in time for the Final Rule, the RUC recommends that this service be carrier priced in 2002.

Vascular Procedures (Tab 30)
Presenters: Gary Seabrook, MD, Society for Vascular Surgery and the American Association for Vascular Surgery
Reviewed by Facilitation Committee 5

35647 (LL1) / 35646 (LL2)

Work Relative Value:

In October 2000, the RUC recommended that code 35646 *Bypass graft, with other than vein; aortofemoral or bifemoral* (work RVU = 25.81) be referred to CPT to split the code before it could be evaluated as an undervalued code as part of the Five-Year Review of the RBRVS. The CPT Editorial Panel then split the code into 35647 *Bypass graft, other than vein; aortofemoral* and 35646 *Bypass graft, other than vein; aortobifemoral*. The specialty surveyed 34 vascular surgeons to obtain a median work RVU of 29.00 for 35647 and 31.00 for 35646. The specialty, however, recommended the 25th percentile for 35647 of 28.00 to retain the appropriate relativity with revised code 35646, as this new code is the same procedure except that only femoral artery dissection and anastomosis is performed, while two femoral anastomoses are performed in revised 35646. The pre- and post-operative care for each procedure is similar. However, 35646 requires an additional 40 minutes intra-service time for the additional anastomosis. The RUC agreed that the current value of 25.81 for the existing 35646 was undervalued and increases to 28.00 and 31.00 were warranted to retain relativity with other vascular procedures increased in this five-year review. The RUC also noted that the frequency of this service has declined by 25% from 1995 to 1999, which supports the specialty's argument that the patient population receiving this service is sicker and more complex as more patients are now being treated with percutaneous angioplasty.

The RUC recommends 28.00 for code 35647 and 31.00 for 35646.

Direct Practice Expense Inputs:

These services are only provided in a facility setting. The RUC recommends the standard practice expense inputs for major surgical procedures with a 090 day global period for codes 35647 and 35646. These inputs are included in a summary of recommendation form.

35685 (LL3)/ 35686 (LL4)

Work Relative Value:

The CPT Editorial Panel created two new add-on codes, as follows: 35685 Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure) and *35686 Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)* to describe rare procedures (<1,000 per year) to improve the poor long term patency rates of long or disadvantaged lower extremity bypass grafts constructed with synthetic conduit. The RUC reviewed these new codes in relation to reference code 35500 *Harvest of upper extremity vein, one segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)* (work RVU = 6.45) and considering data collected from 34 vascular surgeons. The survey respondents indicated that these new add-on codes require 45 minutes and 35 minutes of physician time, respectively. Reference service code 35500 has previous RUC survey time of 60 minutes. Based on the difference in physician time, the RUC agreed that the 25th percentile of the survey work relative value was reasonable for both of these new codes.

The RUC recommends a work relative value of 4.05 for 35685 and 3.35 for 35686.

Direct Practice Expense Inputs:

There are no direct expense inputs as both of these services are add-on codes performed in the facility only.

36819 (LL5) / 36820 (LL6)

The CPT Editorial Panel revised code 36819 *Arteriovenous anastomosis, open; by basilic vein transposition* (work RVU = 14.00) to differentiate between upper arm and forearm vein transposition. A survey of 31 vascular surgeons indicated that there is no difference in physician work between revised code 36819 and 36820.

The RUC recommends a work relative value of 14.00 for both codes 36819 and 36820.

Direct Practice Expense Inputs:

These services are only provided in a facility setting. The RUC recommends the standard practice expense inputs for major surgical procedures with a 090 day global period for these codes. These inputs are included in a recommendation form.

Esophagoplasty for Congenital Defect (Tab 31)
Presenter: Eugene Wiener, MD and Sam Smith, MD, American Pediatric Surgical Association

During the August 2000 5-Year Review, the work relative values for CPT codes 43310 *Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula* and 43312 *Esophagoplasty, (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula* were reviewed. The specialty society's survey results for the August 2001 5-Year Review was restricted to pediatric patients, however the RUC noted that this service may also be performed on adults, and therefore recommended no change in the relative values for these codes. The RUC recommended the specialty society to CPT breaking the procedure into two separate CPT codes. One code for adults and one to reflect the same procedure performed on children. As a result, CPT created CPT codes 43313 *Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula* and 43314 *Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula*.

43310 *Esophagoplasty, (plastic repair or reconstruction), thoracic approach; without repair of tracheoesophageal fistula*

The RUC recommends the current work RVU of 27.47 for CPT code 43310.

43312 ***Esophagoplasty, (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula***

The RUC recommends the current work RVU of 30.50 for CPT code 43312

43313 ***Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula***

The RUC based their recommendation on their understanding that, at the August 2000 5-Year Review, the RUC thoroughly reviewed the specialty society's survey results and approved the values recommended by the specialty, directing the specialty society to return to CPT to create codes for the pediatric population. During the August 2000 5-Year Review, the RUC agreed that the values based on the survey would be appropriate for this procedure performed on critically ill neonates. Critically ill neonates, the specialty argued, required a more extensive and intensive post operative care than for the adult population. The RUC agreed that based on the survey results and relative to CPT code 43314, code 43313 has similar intra-operative time and intensity as well as similar NICU days. Also, CPT code 43313 has similar post-operative visits and time, however to maintain relativity between the two new codes, the RUC recommended a lower work RVU

for 43313 than for 43314, as suggested by the specialty. **The RUC recommends a work relative value of 45.28 for CPT code 43313.**

Practice Expense
The RUC modified the practice expense inputs for CPT code 43313 to include the following, full details of the practice expense inputs are included in the summary of recommendation form.

- 30 minutes of pre-service clinical labor time
- 135 minutes of intra-service clinical labor time
- 197 minutes of post-service clinical labor time from 4 follow up office visits
- 5 multi-specialty minimum visit supply packages
- 1 post operative incision care kit
- 1 exam table and exam lamp

43314 ***Esophagoplasty for congenital defect, (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula***

The RUC based their recommendation on their understanding that, at the August 2000 5-Year Review, the RUC thoroughly reviewed the specialty society's survey results and approved the values recommended by the specialty, directing the specialty society to return to CPT to create codes for the pediatric population. During the August 2000 5-Year Review, the RUC agreed that the values based on the survey would be appropriate for this procedure performed on critically ill neonates. Thirty-one randomly selected pediatric surgeons responded to the survey by the American Pediatric Surgical Association indicating a median work RVU of 50.27. The RUC recognized that the survey responses where tightly centered around the median and the post operative time and visits reaffirmed the specialty's argument that critically ill neonates required a more extensive and intensive post operative care than for the adults.

The RUC recommends a work relative value of 50.27 for CPT code 43314.

Practice Expense
The RUC modified the practice expense inputs for CPT code 43314 to include the following, full details of the practice expense are included in the summary of recommendation form.

- 30 minutes of pre-service clinical labor time
- 148 minutes of intra-service clinical labor time
- 197 minutes of post-service clinical labor time from 4 follow up office visits
- 5 multi-specialty minimum visit supply packages
- 1 post operative incision care kit
- 1 exam table and exam lamp

Repair Small Intestine Atresia (Tab A)
Presenter: Eugene Wiener, MD and Sam Smith, MD, American Pediatric Surgical Association
Reviewed by Facilitation Committee 5

Three new CPT codes were created to describe treatment for congenital small intestine atresias. The surgical techniques for correcting this anomaly are unique to congenital small intestine atresias. Thirty to forty percent of the patients treated by this service are premature newborns. These procedures are extremely rare (less than 250 per year).

44126 ***Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering***
The RUC reviewed the specialty society's survey results from 44 practicing pediatric surgeons. The specialty recommended the 75th percentile of their survey results since the typical patient's are full term and premature infants requiring more extensive post-operative care. Typically, these infants require a length of stay of 21 days after surgery. The RUC agreed that the pediatric surgeon is performing all the post-operative care described by the survey. It is also common for a neonatologist to provide care during this time period. These are extremely rare cases and it is reasonable to assume that more than one physician would be responsible for caring for these newborns. The RUC noted that even if the two critical care visits were converted to level three hospital visits, a computed IWPUT of 0.07 (as described on page 5 of the summary form) justifies the specialty recommendation of 35.50.

The RUC recommends a relative work value of 35.50 for CPT code 44126.

Practice Expense
The RUC reduced the pre-service clinical labor time from the standard 60 minutes for 090 day global period codes, to 30 minutes based on the understanding that the typical patient would be in the hospital already. The RUC recommended direct practice expense inputs for code 44126 are included in the summary of recommendation form.

44127 ***Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering***
The RUC reviewed the specialty society's survey results from 44 practicing pediatric surgeons. The specialty recommended the 75th percentile of their survey results since the typical patient's are full term and premature infants requiring more extensive post-operative care. Typically, these infants require a length of stay of 26 days after surgery. The RUC agreed that the pediatric surgeon is performing all the post-operative care described by the survey. It is also common for a neonatologist to provide care during this time period. These are extremely rare cases and it is reasonable to assume that more than one physician would be responsible for caring for these newborns. The RUC noted that even if the two critical care visits were converted to level three hospital visits, a computed

IWPUT of 0.07 (as described on page 5 of the summary form) justifies the specialty recommendation of 41.00. **The RUC recommends a relative work value of 41.00 for CPT code 44127.**

Practice Expense
The RUC reduced the pre-service clinical labor time from the standard 60 minutes for 090 day global period codes, to 30 minutes based on the understanding that the typical patient would be in the hospital already. The RUC recommended direct practice expense inputs for code 44126 are included in the summary of recommendation form.

44128 – E3 ***Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis of proximal segment of intestine; each additional resection and anatomosis (List separately in addition to code for primary procedure) (Use 44128 in conjunction with 44126, 44127)***

The RUC agreed that the time associated with this code was correct after reviewing three other codes; 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.44), 35600 *Harvest of upper extremity artery, one segment, for coronary artery bypass procedure* (work RVU = 4.95), and 38746 *Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)* (work RVU = 4.39)

Each of these codes have 40 minutes of RUC surveyed physician intra-service time, ZZZ global period, and have similar work intensity as the new code 44128. In addition, the RUC reviewed the reference code 44121 *Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU = 4.45), and believed CPT code 44128 would be more appropriately valued below the specialty society's recommended value and equivalent to its reference code.

The RUC recommends a relative work value of 4.45 for CPT code 44128.

Practice Expense
The RUC recommended no practice expense inputs for this ZZZ day global code, 44128.

<u>Repair of Inguinal Hernia (less than 36 weeks gestation) (Tab B)</u>
Presenter: Eugene Wiener, MD and Sam Smith, MD, American Pediatric Surgical Association

Two new CPT codes were developed and the two existing codes were editorially modified, to distinguish between infants and premature infants who require repair of initial inquinal hernia. The creation of these new codes allows for more

specificity due to a change in the population mix for these types of procedures.

The RUC initially reviewed codes 49495 *Repair initial inquinal hernia, under age 6 months, with or without hydrocelectomy; reducible* (work RVU = 5.89), and 49496 *Repair initial inquinal hernia, under age 6 months, with or without hydrocelectomy; incarcerated or strangulated* (work RVU = 8.79) during the August 2000 5-Year Review. The RUC at that time, recommended no change in the work relative values, but understood that in current practice the patient population and ratio of premature to term babies had changed. Repair of hernia in premature babies is now recommended prior to discharge from the NICU, and the typical patient is now a premature neonate with a very difficult anatomy requiring repair with extensive post operative care. At the August 2000 5-Year Review, the RUC recommended that the specialty make a request to CPT to create new codes specifically for premature infants. As a result, these two new CPT codes were created and the existing codes were modified, to distinguish between full term infant and premature infant repair of inquinal hernia.

49491 ***Repair,initial inquinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; reducible***

The RUC based their recommendation on their understanding that, at the August 2000 5-Year Review, the RUC thoroughly reviewed the specialty society's survey results and approved the values recommended by the specialty, directing the specialty society to return to CPT to create codes for the premature infant population. During the August 2000 5-Year Review, the RUC agreed that the values based on the survey would be appropriate for this procedure performed on premature infants. Premature infants, the specialty argued, have more difficult anatomy's and require more extensive and intensive post operative care than for the full term infants. In addition, the RUC compared the intra-service work and intensity of 49491 to the reference code 44950 *Appendectomy* (work RVU = 8.70), and believed they were similar. Code 49491 was reported to have 10 minutes more intra-service physician time, and more extensive post-operative care than 44950. The RUC agreed with the specialty society's recommendation to value this code at the 25th percentile of the specialty's survey results.

The RUC recommends a relative work value of 11.13 for CPT code 4941.

Practice Expense
The RUC recommended the standard 090 day global practice expense package for code 49491. The details of the practice expense direct input recommendation are included in the summary of recommendation form.

49492 ***Repair, initial inquinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; incarcerated or strangulated***

The RUC based their recommendation on their understanding that, at the August 2000 5-Year Review, the RUC thoroughly reviewed the specialty society's survey results and approved the values recommended by the specialty, directing the specialty society to return to CPT to create codes for the premature infant population. During the August 2000 5-Year Review, the RUC agreed that the values based on the survey would be appropriate for this procedure performed on premature infants. Premature infants, the specialty argued, have more difficult anatomy's and require more extensive and intensive post operative care than for the full term infants. In addition, the RUC compared the intra-service work and intensity of 49492 to the reference code 44950 *Appendectomy* (work RVU = 8.70), and believed they were similar. Code 49492 was reported to have 10 minutes more intra-service physician time, and more extensive post-operative care than 44950. CPT code 49492 in addition has more pre and post service time and intensity than its anchor code 49491 due to compromised bowel and gonad, these may require one more hospital day. The RUC agreed with the specialty society's recommendation to value this code in relation to code 49491.

The RUC recommends a relative work value of 14.03 for CPT code 49492.

Practice Expense
The RUC recommended the standard 090 day global practice expense package for code 49491. The details of the direct inputs recommendation are included in the summary of recommendation form.

Laparoscopic Colectomies (Tab C)
Presenter: Anthony Senagore, MD and Martin Luchtefeld, MD, American Society of Colon and Rectal Surgeons

The CPT Editorial Panel approved three new codes to describe laparoscopic colon procedures. The RUC reviewed codes 44204 *Laparoscopy, surgical; colectomy, partial with anastomosis* and 44205 *Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocecostomy* at the February 2001 RUC meeting. The RUC reviewed code 44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)* at the April 2001 RUC meeting.

44203 *Laparoscopy, surgical; each additional small intestine resection and anastomosis (list separately in addition to code for primary procedure):*

The CPT Editorial Panel created new code 44203 as the current code 44202 *Laparoscopy, surgical; intestinal resection with anastomosis (intra or extracorporeal)* (work RVU = 22.04) only described the work of a single resection and anastomosis. The RUC reviewed survey data from 30 colon and rectal surgeons and compared this code to 44121 *Enterectomy, resection of small intestine; each additional resection and anastomosis (list separately in addition to*

code for primary procedure) (work RVU = 4.45). Both add-on procedures describe similar work and require one-hour of intra-service time. **The RUC recommends a work relative value of 4.45 for code 44203.**

Direct Practice Expense Inputs:

This is an add-on code performed in a facility setting. Therefore, there are no direct practice expense inputs attributed to this service.

44204 ***Laparoscopy, surgical; colectomy, partial with anastomosis:***

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated a median survey work relative value of 22.00. The survey time for this procedure (45 minutes pre, 180 minutes intra, 30 minutes immediate post, 4 hospital visits, discharge day management, and 3 office visits) was compared to the existing RUC database time for CPT code 44140 *Colectomy, partial; with anastomosis* (work RVU = 18.35) (90 minutes pre, 150 minutes intra, 40 minutes immediate post, 6 hospital visits, discharge day management, and 3 office visits). The RUC focused its review on the increased intra-service time required with 44204 (180 vs. 150 minutes) and also considered that the survey respondents indicated that the laparoscopic approach was more intense than 44140.

The RUC recommends a work relative value of 22.00 for code 44204.

Direct Practice Expense Inputs:

This service is only performed in the facility setting. The RUC utilized the PEAC proposed 90 day standard direct inputs for this service, as described on the summary form.

44205 ***Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocecostomy:***

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated a median survey work relative value of 19.50. The survey time for this procedure (47.5 minutes pre, 165 minutes intra, 30 minutes immediate post, 5 hospital visits, discharge day management, and 3 office visits) and compared it to the existing RUC database time 44160 *Colectomy, partial; with removal of terminal ileum ~~and~~ with ileocolostomy* [work RVU = 15.88 (2001 MFS); 18.62 (Five-Year RUC Rec.)] (63 minutes pre, 120 minutes intra, 45 minutes immediate post, 6 hospital visits, discharge day management, and 3 office visits). The RUC focused its review on the increased intra-service time required with 44205 (165 vs. 120 minutes) and also considered that the survey respondents indicated that the laparoscopic approach was more intense than 44160.

The RUC recommends a work relative value of 19.50 for CPT code 44205.

Direct Practice Expense Inputs:

This service is only performed in the facility setting. The RUC utilized the PEAC proposed 90 day standard direct inputs for this service, as described on the summary form.

The RUC noted that the committee created a rank order anomaly in reviewing the corresponding open procedures 44140 and 44160 during the recent Five-Year Review. These codes were classified into two separate families at the October 2000 Workgroup meetings. The family with code 44160 was increased (RUC recommended work = 18.62), the family with code 44140 (2001 work RVU = 18.35), was not increased as 44140 had previously been reviewed in 1995, in the first five-year review. The RUC agrees that CPT code 44140 should be valued higher than 44160.

Placement of Anal Seton and Excision of Ileoanal Resevoir (Tab D)
Presenter: Anthony Senagore, MD and Martin Luchtefeld, MD, American Society of Colon and Rectal Surgeons

46020 ***Placement of seton:***

Code 46020 was created to describe placement of a seton as a stand-alone procedure, as this service is being more frequently performed as a separate procedure and not in conjunction with other procedures.

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated that this service typically requires 20 minutes of pre-time, 35 minutes intra-time, 20 minutes immediate post-op, 18 minutes (50% of discharge day mgt), and 2 office visits. The survey respondents indicated that this service was similar in time and intensity to 46230 *Excision of external hemorrhoid tags and/or multiple papillaw* (work RVU = 2.57).

The RUC recommends the survey median of 2.90 for code 46020.

Practice Expense:

The RUC modified the specialty's submitted practice expense inputs for both the office and out-of-office settings for code 46020 to be consistent with the approved practice expense inputs for major surgical procedures. The medical supplies were also modified for the in-office setting. A summary form with the recommended practice expense inputs will be appended to the recommendation.

45136 ***Excision of ileoanal reservoir with ileostomy:***

A new CPT code was created to describe the removal of an ileoanal pouch due to problems with function or sepsis. The ileoanal pouch procedure is a relatively new surgery and there is currently no way to report this removal.

The RUC reviewed survey data from 38 colon and rectal surgeons that indicated that this service typically requires 40 minutes or pre-time, 240 minutes intra-time, 30 minutes immediate post-operative time, one critical care visit, 7 hospital visits, discharge day management, and 4 office visits. The data from the survey derived a survey median of 25.00, however, the specialty society compared this service to code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 22.59 (2001 MFS), 25.36 (RUC Five-Year Rec.) and recommends a work relative value of 27.30. 44626 was recently surveyed in the Five-Year Review and requires the following time: 60 minutes pre-time, 150 minutes intra-time, 30 minutes immediate post-time, 7 hospital visits, discharge day management, and 2 office visits. The RUC considered the significantly higher intra-service time for 45136 (240 minutes vs. 150 minutes) and agreed that a work relative value of 27.30 is appropriate.

The RUC recommends a work relative value of 27.30 for code 45136.

Practice Expense:

The RUC reviewed the direct practice expense inputs for this code and suggests revisions to be consistent with the standards proposed by the PEAC for 90-day major surgical procedures. A summary sheet listing these inputs will be attached to the recommendation.

<u>Ablation of Hepatic Tumors (Tab E)</u>
Presenter: Robert Vogelzang, MD, Society for Cardiovascular and Interventional Radiology
Reviewed by Facilitation Committee 6

Codes 47370 – 47381 will be reviewed by the RUC at the September 2001 meeting. If HCFA is unable to review recommendations from this meeting in time for the Final Rule, the RUC recommends that these services be carrier priced in 2002. The RUC was unable to evaluate codes 47382, 76362, 76394, and 76490 at this time due to continued confusion over the appropriateness of reporting ultrasound guidance separately from the primary procedure. The CPT Editorial Panel will provide further clarification of this issue. The RUC will review these codes in September 2001.

Gynecological Oncology Procedures (Tab F)
Presenter: Michael Berman, MD, American College of Obstetricians and Gynecologists
Reviewed by Facilitation Committee 6

The CPT Editorial Panel approved four new gynecological oncology procedures for CPT 2002 to correct current gaps in coding that would 1) allow the physicians who insert uterine tandems, vaginal ovoids, or Heyman capsules so that a radioelement for brachytherapy may be inserted by the radiation oncologist to report their services; and 2) provide more accurate description of bilateral salpingo-oophorectomy procedures.

57155 ***Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy:***

The RUC reviewed survey data from 24 gynecologists for 57155. This data indicates that this service requires 47.5 minutes pre-time, 55 minutes intra-time, 20 minutes immediate post, 2 hospital visits, discharge day management, and 2 office visits. The survey respondents had indicated that the work was nearly twice that of CPT code 58120 *Dilation and curettage, diagnostic or therapeutic* (work RVU = 3.27) (35 minutes pre-time, 25 minutes intra-time, 27 minutes post-time, 1 hospital visit, discharge day management, and 1 office visit – per RUC database). The specialty indicated that the placement of tandems and ovoids requires repeated manipulation of the devices, as well as careful packing to ensure that the tandems and ovoids remain securely in place. This activity requires a significantly higher level of technical skill than the service described in 58120. The survey indicated that this service was more intense than 58120 in each category. The RUC agreed that the survey median was appropriate.

The RUC recommends a work value of 6.27 for CPT code 57155.

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 day global major surgical procedures as described on the attached summary. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

58346 Insertion of Heyman capsules for clinical Brachytherapy:

The RUC reviewed survey data from 22 gynecologists for 58346. This data indicates that this service requires 50 minutes pre-time, 60 minutes intra-time, 20 minutes immediate post, 2 hospital visits, discharge day management, and 2 office visits. The survey respondents had indicated that the work was nearly twice that of CPT code 58120 *Dilation and curettage, diagnostic or therapeutic* (work RVU = 3.27) (35 minutes pre-time, 25 minutes intra-time, 27 minutes post-time, 1

hospital visit, discharge day management, and 1 office visit – per RUC database). The specialty indicated that the placement of tandems and ovoids requires repeated manipulation of the devices, as well as careful packing to ensure that the capsules remain securely in place. This activity requires a significantly higher level of technical skill than the service described in 58120. The survey indicated that this service was more intense than 58120 in each category. The specialty felt that the survey median of 8.34 was overstated as the procedure is rare and the survey respondents may have been unfamiliar with the procedure. 58346 requires slightly more work than 57155, therefore, the RUC recommends the 25th percentile of the survey.

The RUC recommends a work value of 6.75 for CPT code 58346.

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 day global major surgical procedures as described on the summary form. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

58953 ***Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking:***

The CPT Editorial Panel created new code 58953 to accurately describe a service that is not currently described in CPT. Currently, this services is reported as follows:

58952	Resect ovarian malignancy	25.01
58150-51	Total hysterectomy (15.24*.50)	7.62
Total current value when performing this service		32.63

The RUC reviewed the survey data from 51 gynecology oncologists and determined that the survey median of 32.00 was appropriate and compared to the total work relative value listed above. The RUC did not accept the pre-service time of 150 minutes as typical, however, and adjusted this time to 90 minutes.

The RUC recommends a work RVU of 32.00 for 58953.

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 day global major surgical procedures as described on the summary form. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

58954 ***Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenecotmy and limited para-aortic lymphadenectomy:***

The CPT Editorial Panel created new code 58954 to accurately describe a service that is not currently described in CPT. Currently, this services is reported as follows:

58952	Resect ovarian malignancy	25.01
58150-51	Total hysterectomy (15.24*.50)	7.62
38770-51	**Remove pelvis lymph nodes (13.23*.50)**	**6.62**
Total current value when performing this service		**39.25**

The RUC reviewed the survey data from 41 gynecology oncologists and determined that the survey median of 35.00 was appropriate and compared to the total work relative value listed above. The RUC did not accept the pre-service time of 150 minutes as typical, however, and adjusted this time to 90 minutes.

The RUC recommends a work RVU of 35.00 for 58954.

Practice Expense:

This service is only performed in the facility setting. The RUC recommends the PEAC proposed standardized package for 90 day global major surgical procedures as described on the summary form. The ob-gyn supply package for an office visit should be used in lieu of the standard minimum supply package.

Therapeutic Amniotic Fluid Reduction (Tab G)
Presenter: Sandra Reed, MD, American College of Obstetricians and Gynecologists

The CPT Editorial Panel created a new code 59001 *Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)* to describe the removal of large amounts of amniotic fluid for massive polyhydramnos and twin-twin transfusion. CPT code 59000 *Amniocentesis; diagnostic* was editorially revised to clarify that this service is a diagnostic service and the code had not been utilized for the services now described in 59001.

The RUC recommends a work relative value of 1.30 (no change – editorial revision) for code 59000.

The RUC reviewed the survey results from 55 obstetricians and maternal-fetal medicine specialists and agreed that the survey median of 3.00 was appropriate. The RUC clarified that there is often no other CPT codes reported in conjunction with this service. This service requires 40 minutes pre-time, 45 minutes intra-time, and 20 minutes post-time. The RUC also compared this work RVU

recommendation to existing codes from other specialties that have also been surveyed by the RUC. CPT code 52007 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis* (work RVU = 3.02) has RUC survey time of 38 minutes pre-, 45 minutes intra-, and 30 minutes post-time. CPT code 43249 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)* (2001 work RVU = 2.90; RUC 5-Year Review Rec.= 3.35) has RUC survey time of 42 minutes pre-, 39 minutes intra-, and 26 minutes post. Based on the review of all of this information, the **RUC recommends a work relative value of 3.00 for code 59001.**

Practice Expense:

This service is provided in a facility setting only. The RUC agreed with the specialties recommended direct practice expense inputs, which are 20 minutes of RN/LPN/MA time for pre-service counseling and coordination of care and no medical supplies or equipment.

Radiotherapy (Tab H)
Presenters: Paul Wallner, DO, Michael Steinberg, MD, Louis Potters, MD, and James Hevezi, PhD, American Society of Therapeutic Radiology and Oncology
Reviewed by Facilitation Committee 2

Code 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* was created to describe a new computer based method of planing for and delivering radiotherapy. Although the specialty society originally recommended a value greater than the survey median, the RUC concluded and the specialty society agreed that a more appropriate recommendation would be the survey median of 8.00. To validate the survey median, the RUC considered the following additional rationale:

Building Block of Current Codes:

77295 *Set radiation therapy field*	4.57
77331 *Special radiation dosimetry (0.87 x 3)*	2.61
76370 *CAT scan for therapy guide*	0.85
76375 3d/holograph reconstr add-on	0.16
Total	**8.19**

The RUC also recommends that the CPT Editorial Panel consider adding a note to CPT to specifically exclude the reporting of the above codes in conjunction with 77301.

Intensity Calculation:

Median Survey Pre-Time 30 minutes x .0224 0.67

Intra-Service Time:

10-25 minutes:
- immobilize patient in treatment position for tumor volume localization CT

5-10 minutes:
- correlate planning CT scan used for tumor localization with other imaging studies, including MRI, PET, contrast enhanced plain film studies, and ultrasound imaging studies

10-15 minutes:
- enumerate critical normal tissues within and adjacent to tumor volume
- define partial dose/volume tolerances for these normal tissues

25-25 minutes:
- identify and segment tumor area on each CT slice within tumor volume
- identify and segment each critical normal tissue within each CT slice within and adjacent to tumor volume

5-10 minutes:
- explicitly develop normal tissue and tumor dose constraints for inverse planning algorithm
- for Peacock planning determine 1 or 2 cm index slice thickness
- for multi-leaf collimator IMRT work with physicist to suggest initial gantry and table angles for field families

20-30 minutes:
- evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints

5-10 minutes:
- work with physicist to modify tumor and normal tissue dose constraints if necessary to re-run plan
- continue to iterate plan until dose constraints are acceptable

5-8 minutes:
- specifically compare dose volume histograms for tumor and critical normal tissues

10-15 minutes:
- review phantom/film, TLD, or diode dosimetry performed by physicist to confirm correct plan parameters compared with graphical plan

Total Physician Intra-Time as Reviewed in Detail (95-158 minutes)

75th Percentile of the Survey = 131 minutes

IWPUT 0.050 x 131 minutes = 6.55

Post-Service Time 35 minutes x .0224 = 0.78

Pre (0.67) + Intra (6.55) + Post (0.78) = 8.00. This comparison validates the survey median of 8.00.

The RUC recommends that 131 minutes be utilized as the intra-service time for this service.

The RUC recommends a work relative value of 8.00 for CPT code 77301.

Practice Expense
The RUC examined revised practice expense inputs from the specialty provides revised inputs that are included on a summary form. The revisions included deletion of items considered to be overhead and not appropriate as direct cost inputs. The remaining supplies and equipment are directly related to the provision of this procedure. The RUC reviewed each element of clinical staff time in comparison to the activities performed by the physician.

The RUC recommends direct practice expense inputs for services performed in the office setting only.

Radiation Treatment Therapy (Tab I)
Presenters: Paul Wallner, DO, Michael Steinberg, MD, Louis Potters, MD, and James Hevezi, PhD, American Society of Therapeutic Radiology and Oncology
Reviewed by Facilitation Committee 2

The specialty society presented only practice expense direct inputs for code 77418 *Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams (binary, dynamic MLC, etc.), per treatment session* since there is no physician work associated with this code. This code was created to describe a new method of providing radiation treatment. The RUC made a number of changes to the inputs including using the standard staff mix of RN/LPN/MA for some activities and also deleting a number of supplies that were then grouped into the minimum supply package. Also, the RUC agreed with the specialty that two radiation therapists are involved in providing this service.

Pulsed Irrigation of the Bowel (Tab J)
Presenter: Joel Brill, MD, American Gastroenterological Association

The specialty society initially proposed only practice expense inputs for code 91123 *Pulsed irrigation of fecal impaction* since there was no physician work

associated with this procedure. The RUC agreed that this procedure is performed by non-physician clinical labor and not by physicians so there should be no physician work RVUs assigned to this code. Also, since the procedure is performed in a facility setting, not a physician's office, the RUC concluded that there should not be any direct practice expenses assigned to this code.

The RUC recommends a zero physician work value and zero practice expense inputs for the facility setting for code 91123.

Noninvasive Anterior Chamber Biometry (Tab K)
Presenter: Trexler Topping, MD, American Academy of Ophthalmology

Code 92136 *Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation* was created to describe optical coherence measurement for intraocular lens measurement and calculation. The RUC examined a request from the American Academy of Opthamology to cross walk the work relative value from code 76519 *Ophthalmic biometry by ultrasound echography, A-scan, with intracular lens power calculation.* (work RVU = .54). The RUC agreed that the number of images, the mental effort and judgement, technical skill, time and iatrogenic risk are the same for both codes and therefore concluded for this code, crosswalking values was appropriate.

The RUC recommends a physician work value of .54 for code 92136.

Practice Expense
The RUC recommends crosswalking the practice expense for code 76519 with the addition of a $25,000 optical coherence biometer as the medical equipment and modifications to the supplies and other equipment.

Implantation/Removal of Ventricular Assist Device (Tab L)
Presenter: Sidney Levitsky, MD, Society of Thoracic Surgeons

Two codes were created and three existing codes were editorially revised to differentiate insertion and removal of extracorporeal and intracorporeal ventricular assist devices. The specialty society initially was prepared to present its recommendation for new CPT codes 33979 *Insertion of ventricular assist device; implantable intracorporeal, single ventricle* and 33980 *Removal of ventricular assist device; implantable intracorporeal, single ventricle,* however, upon further review of the survey responses the specialty society concluded that the survey respondents did not accurately assess the time required for these procedures due to a comparison with the reference code that had a 90 day global period. Additionally, within the next several months data from an NIH study of 20 institutions using this new technology will become available. The specialty society requested to bring these codes back to the RUC when the supporting institutional data from the NIH study are available. In the interim, the specialty society requested that the codes be carrier priced for 2002. The RUC agreed with

the specialty society request that the codes be carrier priced for a year. **The RUC recommends that codes 33979 and 33980 be carrier priced for 2002.**

Percutaneous Transluminal Coronary Thrombectomy (Tab M)
Presenter: James Maloney, MD and Joseph Babb, MD, American College of Cardiology

A new code was created to capture a new technique of removing thrombus in native coronary arteries and coronary saphenous vein grafts (SVG), for patients with AMI, unstable angina, and degenerated SVG disease.

The RUC reviewed the survey results from 28 practicing cardiologists, and believed that the work associated was quite similar to the reference code 92996 *Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 3.26). The specialty society valued this new code slightly higher than the reference code to avoid a rank order anomaly. The code's vignette drew attention by the RUC members as it described the entire process encompassing several separate codes, however the specialty society survey specifically asked for the incremental work associated to this add-on code. The description of intra-service work also indicated that there were other separately billable items, and this helped the RUC understand how the survey respondents valued the amount of work associated with this particular code. The RUC believed that the survey results indicating 40 minutes of intra-service time for the withdrawal, replacement, and multiple passes to remove the thrombus was reasonable. The RUC accepted the specialty society's survey median.

The RUC recommends a relative work value of 3.28 for CPT code 92973.

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

Transcatheter Placement of Radiation Delivery Device (Tab N)
Presenter: James Maloney, MD and Joseph Babb, MD, American College of Cardiology
Reviewed by Facilitation Committee 6

A new code was created to identify the new technique of using catheter-based radiation (Gamma or Beta) to treat patients with restenosis of previously place coronary stents. It is performed in an interventional cardiac catheterization

laboratory as an adjunctive procedure to balloon angioplasty, atherectomy, or coronary stent placement.

The RUC reviewed the survey results for this new code and questioned whether or not the respondents valued the work increment correctly. The RUC understood that the work intensity of the cardiologist for this code, was similar to the intensity of other codes billed at the same time. The work of the cardiologist includes being careful not to let the radiation seeds drift away from the targeted area damaging healthy tissue, and therefore must monitor their placement frequently. The cardiologist also has the responsibility of placing the seeds which is the most intense time period of the procedure. Additionally, the RUC wanted to avoid a rank order anomaly within the code's family, noting that code 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure) (Use 92973 in conjunction with 92980, 92982* (RUC recommended value = 3.28) had been reviewed and accepted earlier that day. The RUC recommended a value below specialty's recommended value and survey median.

The RUC recommends a work relative value of 3.00 for CPT code 92974.

Practice Expense

The RUC recommended no practice expense direct inputs for this ZZZ global period code.

Microvolt T-wave Alternans Assessment of Ventricular Arrhythmia (Tab O)
Presenter: James Maloney, MD and Joseph Babb, MD, American College of Cardiology
Reviewed by Facilitation Committee 6

A new code was created to describe the new technology of a microvolt T-wave alternans test for the assessment of patients risk of patients at risk of ventricular tachyarrhythmias leading to sudden cardiac death.

93025 ***Microvolt T-wave alternans for assessment of ventricular arrhythmias***

The RUC reviewed the specialty society's survey results of 26 practicing cardiologists who perform this procedure, and believed that the physician work involved was similar to the standard stress test code 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report* (work RVU = 0.75), which is included on the RUC's multi-specialty points of comparison list. The RUC believed that this code would be appropriately valued at the same level as code 93015 considering its similarity in physician work.

The RUC recommends a relative value of 0.75 for CPT code 93025.

Practice Expense

The RUC reviewed the practice expense direct inputs for code 93025 presented by the specialty society, and made the following changes:

- The clinical labor staff type was changed to RN/LPN/MA and the total clinical time was reduced to 53 minutes to reflect current PEAC standards and the actual time the staff assisted the physician during the test
- The skin marking pens were deleted since it can be used multiple times
- The minutes of use per procedure for the treadmill and CH2000 Alternans System were reduced to 15 minutes to reflect the actual time used

The full RUC recommended practice expense direct inputs for code 93025 are included in the summary of recommendation form.

Thoracic Electrical Bioimpedance (Tab P)
Presenter: James Maloney, MD and Joseph Babb, MD, American College of Cardiology
Reviewed by Facilitation Committee 6

A new CPT code was developed to record the use of a new device that monitors cardiac output. The physician's use this device is to obtain a diagnostic cardiac assessment of the patient.

The RUC reviewed the history of this code and agreed that the physician work of reviewing this computer generated print out is included in the E/M code service as directed in the CPT note following this code.

The RUC recommends a relative work value of 0.00 for code 93701.

Practice Expense

The RUC modified the practice expense inputs to reflect the standard clinical labor staff type and times. The details of the direct practice expense for this code are included on the summary of recommendation form.

Intracardiac Electrophysiology (Tab Q)
Presenter: James Maloney, MD and Joseph Babb, MD, American College of Cardiology
Reviewed by Facilitation Committee 6

The CPT Editorial Panel for CPT 2002 deleted 3 codes, revised 3 codes to be add-on codes, editorially changed 2 codes, and created 1 new code, in order to provide further clarification of the use of certain cardiac electrophysiology procedures,

update current terminology related to the technology involved, and to accurately depict the continued technologic changes.

93609 ***Intraventricular and/or intra-atrial intracardiac electrophysiologic mapping of tachycardia site(s) with 3-dimensional mapping or catheter manipulation to record from multiple sites to identify origin of tachycardia***

In May 2001 the CPT Editorial Panel clarified this service to be an add-on code, instead of the currently assigned global period of 000 day. The RUC will review 93609 at the September 2001 RUC meeting.

93619 ***Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia***
(Do not report 93619 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93620-93622)

The RUC recommends the current work RVU of 7.32 for CPT code 93619 as the CPT change was editorial and did not change the work of the service.

93620 ***Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters, with induction or attempted induction of arrhythmia; (Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)***

The RUC recommends the current work RVU of 11.59 for CPT code 93620 as the CPT change was editorial and did not change the work of the service.

93621 ***Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)(Use 93621 in conjunction with 93620)***

The RUC compared the survey results of code 93621 to add-on code 47550 *Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)* (work RVU = 3.02), and to the base code 93620 *Comprehensive elctrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; (Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)* (work RVU = 11.59). The RUC believed that code 93621 and 47550 had the similar work time of 30 minutes, but an intensity of code 93620. The RUC wanted to maintain the

intensity associated with the type of procedure involved, yet maintain some relativity across specialties. The RUC believed code 93621 was less work than code 47550 and had the intensity of the base code 93620 with an intra-operative work intensity of 0.07 (calculated from RUC survey data). The RUC recommended a value below the specialty society's recommended value and survey median, and used an intra-operative work intensity of 0.07 multiplied by 30 minutes of intra-service time to support its recommendation. In addition, the RUC wanted to maintain rank order between other codes such as 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure) (Use 92973 in conjunction with 92980, 92982)* (RUC recommended work value = 3.28) containing 40 minutes of intra-service time and an IWPUT = 0.08.

The RUC recommends a relative work value of 2.10 for CPT code 93621.

Practice Expense:

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

93622 ***Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure) (Use 93622 in conjunction with 93620)***

The RUC compared the survey results of code 93622 to code 93620 *Comprehensive elctrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording, including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; (Do not report 93620 in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)* (work RVU = 11.59). The RUC believed that CPT code 93622 had the similar work intensity of code 93620 and the RUC wanted to maintain the intensity associated with the type of procedure, recognizing its surveyed 45 minutes of intra-service time. With this in mind, the RUC used an intra-operative work intensity of 0.07 (calculated from RUC survey data of code 93620), and multiplied by 45 minutes of intra-service time to support its recommended value. The RUC recommended a work relative value below the 25th percentile of the specialty society's survey.

The RUC recommends a relative work value of 3.10 for CPT code 93622.

Practice Expense:

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

93613 ***Intracardiac electrophysiologic 3-dimensional mapping***

The RUC recommends this new code to be referred back to CPT for clarification, and that it remain carrier priced at this time. The CPT Editorial Panel clarified this service to be an add-on code. The RUC will review 93613 during its September 2001 meeting.

Neurology Procedures (Tab R)
Presenters: Benjamin Brooks, MD, Gregory Barkley, MD, and Baldwin Smith, American Academy of Neurology; Arliss Pollock, American Society of Neuroradiology
Reviewed by Facilitation Committee 5

95875 ***Ischemic limb exercise test with serial specimen(s) acquisition for muscle metabolite(s)***

CPT code 95875 was revised to more accurately describe the ischemic limb exercise test. The RUC evaluated the physician work required to perform the test and the level of physician decision making. Normally the test is performed when there is suspicion of muscle disease and the test is used to measure the capability of the body's enzymes to convert pyruvate to lactate in the venous circulation of an exercising muscle. This code was examined in comparison to evaluation and management codes such as 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.* (work RVU = 1.10) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family* (work RVU = 1.40). The RUC agreed that the procedure requires a level of physician judgment necessary to prevent complications and to obtain valid test results that is comparable to the work of a level four established patient office visit. Although the Specialty Society recommended the median survey value, the RUC concluded that this overstated the work involved in relation to the E/M codes and therefore decided that the 25% value of 1.10, more accurately described the physician work and was equivalent to the work involved in code 99214. **The RUC recommends a work relative value of 1.10 for CPT code 95875.**

Practice Expense
The RUC accepted the specialty society recommended inputs in the office setting with a change to the clinical staff mix to reflect a mix of RN/LPN/MA. The RUC recommends no direct practice expense when performed in the facility setting.

95965 ***Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization).***

The RUC concluded that the median survey value of 8 work RVUs was appropriate for code 95965. Although the specialty society recommended a higher value, the RUC concluded that time and intensity data only supported the median survey value when compared to the reference code 95951 *Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours* (work RVU = 6.00).

The RUC recommends a work relative value of 8.00 for CPT code 95965.

Practice Expense
The RUC agreed with the specialty society that the code is only performed in the facility setting and therefore has no practice expense direct inputs.

95966 ***Magnetoencephalography (MEG), recording and analysis for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)***

The RUC compared code 95966 to reference code 95961 *Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance* (work RVU = 2.97). As the new code has greater physician time of 15 minute pre-service, 75 minutes intra-service, and 30 minutes post-service, as compared to 65 minutes of Harvard time for the reference code, the RUC felt that a value of 4 work RVUs would be appropriate and result in a proper rank order for this code family.

The RUC recommends a work relative value of 4.00 for CPT code 95966.

Practice Expense
The RUC agreed with the specialty society that the code is only performed in the facility setting and therefore has no practice expense direct inputs.

95967 ***Magnetoencephalography (MEG), recording and analysis for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)***

The RUC compared CPT Code 95967 *Magnetoencephalography (MEG), recording and analysis for evoked magnetic fields, each additionalmodality (eg, sensory, motor, language, or visual cortex localization) modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure*) to the reference code 95962 *Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure)* (work RVU = 3.21). Given the new code has an intra-service time of 75 minutes, compared to the reference code with a time of 70 minutes, the RUC concluded that the value of this new procedure should be slightly higher than the reference procedure and agreed that the survey median value of 3.50 accurately represented the work involved with this code.

The RUC recommends a work relative value of 3.50 for CPT code 95967.

Practice Expense
The RUC agreed with the specialty society that the code is only performed in the facility setting and therefore has no practice expense direct inputs.

Photodynamic Therapy - Destruction of Skin Lesions (Tab S)
Presenters: Stacy Smith, MD and Brett Coldiron, MD, American Academy of Dermatology

Code 96567 *Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drugs(s), each phototherapy exposure session*, was created to describe a photodynamic therapy treatment, a new technology recently approved by the FDA. The procedure involves application of a photo-sensitizing agent followed by exposure to special ultra-violet light. A survey of 39 dermatologists using this new technology indicated that there was some physician work for this XXX global period procedure (96567). However, upon review of the survey responses, the specialty society concluded that the respondents did not accurately assess the time required by the physician for this procedure using the new technology and included a written recommendation that for the typical patient receiving this procedure, there is no physician work. The RUC agreed that the procedure, using this new technology, does not involve physician work but does involve practice expense direct inputs.

The RUC recommends a work relative value of 0 for CPT code 96567.

Practice Expense:
The typical patient undergoing this procedure typically requires two encounters and the direct inputs have been adjusted to reflect this. Since the first treatment is usually performed on the same day as an E/M visit, the inputs were adjusted to prevent double counting with the inputs already included in the E/M services. For

example, the minimum supply package was reduced to one to reflect only the second treatment. Also, the clinical staff times were reduced to reflect an E/M visit on the day of the first treatment. These are inputs for the office setting only. If the procedure is performed in the facility, there would be no direct inputs for this code.

Doctor J. Leonard Lichtenfeld, MD did not participate in the discussion or vote on this issue.

Analysis of Computer Transmitted Data (Tab T)
Presenters: Sethu Reddy, MD, American Association of Clinical Endocrinologists and M. Douglas Leah, MD, American College of Physicians-American Society of Internal Medicine

The CPT Editorial Panel created a new code 99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time* to specifically describe the review of data sent to the physician electronically from a patient and/or caregiver for their analysis and interpretation. This service may be reported only once per month and may not be reported in conjunction with an Evaluation and Management service on the same day. This service may also not be reported in conjunction with a care plan oversight code (99374-99380).

The RUC carefully reviewed the survey results from 58 internists and endocrinologists. The survey median reflected a work relative value of 1.20, however, the specialty recommended that the code be valued similar to the care plan oversight services at 1.73. The RUC reviewed the time involved and did not agree that this was an appropriate comparison. The RUC reviewed the time data of 5 minutes pre-time, 20 minutes intra-time, and 5 minutes post-time and compared this to the physician time and intensity involved in CPT code 99214 *Level 4 Established Office Visit* (work RVU = 1.10) with intra-time of 25 minutes, and a total time of 38 minutes, and determined that 99091 should be valued at this level. The RUC also agreed that the intra-service time for this code should be modified to be 30 minutes as the CPT descriptor clearly states that the physician must spend a minimum of 30 minutes to report this service.

The RUC recommends a work relative value of 1.10 for code 99091.

Practice Expense:

There are no direct practice expense inputs related to this service.

Continuous Glucose Monitoring System (Tab U)
Presenters: Sethu Reddy, MD, American Association of Clinical Endocrinologists and M. Douglas Leah, MD, American College of Physicians-American Society of Internal Medicine

The CPT Editorial Panel created a new code 95250 *Glucose monitoring for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor (includes hook-up, calibration, patient initiation and training, recording, disconnection, downloading with printout of data)* to describe the technical portion of this service. The physician review, interpretation and written report associated with this service would be reported utilizing the Evaluation and Management service codes.

The RUC recommends zero physician work for 95250.

The RUC revised the direct practice expense inputs for this service. The clinical staff time was reduced from the specialty's recommendation and the minimum supply kit was eliminated as that would be captured in the associated Evaluation and Management service. These revised practice expense inputs are included in a summary of recommendation form.

Patient Transport (Tab V)
Presenter: Steven Krug, MD, American Academy of Pediatrics and William Peruzzi, Society of Critical Care Medicine

The CPT Editorial Panel created two new codes 99289 *Physician constant attention of the critically ill or injured patient during an interfacility transport; first 30-74 minutes* and 99290 *Physician constant attention of the critically ill or injured patient during an interfacility transport; each additional 30 minutes (List separately in addition to code for primary service)* to describe these interfacility transports involving physicians. The face-to-face time begins when the physician assumes primary responsibility of the patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be reported.

The RUC reviewed survey data from 56 critical care, neonatology, and burn care physicians. This data indicated a survey median of 4.80 and a 75th percentile of 6.00. The specialty chose to recommend the 75th percentile as they argued that this was more reflective of the intense service that is provided. The specialty also presented information regarding the risk to the physician of such emergency travel, indicating that 2 out of every 1,000 helicopter flights results in a crash involving fatalities and/or injuries. The specialty also indicated that the level of intensity for this service is greater than critical care services as the physician is not working within their own facility and must assist in stabilizing the patient in a different facility or location. The survey respondents also confirmed that they

believed these services to be more intense than the critical care services, codes 99291 and 99292. Although, the RUC agreed that these services were certainly more intense that the critical care services, the committee did not agree that they should be valued at the level of 6.00 and 3.00. The RUC agreed that the survey was well conducted and understood by the respondents, and recommends that the survey median of 4.80 for 99289 is appropriate. A work relative value of 2.40 (1/2 of 4.80) would be appropriate for 99290.

The RUC recommends a work relative value of 4.80 for 99289 and 2.40 for 99290.

Practice Expense:

There are no direct practice expense inputs associated with this service.

XII. **Relative Value Recommendations – Requests from HCFA:**

Gynecology Procedures (Tab W)
Presenters: George Hill, MD and Sandra Reed, MD, American College of Obstetricians and Gynecologists

HCFA requested that the RUC review CPT codes 56605, 56810, and 58100. The RUC is recommending no change in codes 56605 and 56810 as explained below. The RUC is recommending an increase for code 58100 and recommending revised direct practice expense inputs for this service.

56605 Biopsy of vulva or perineum (separate procedure); one lesion

This code was reviewed in the first five-year review, and was increased to double the original work RVUs for this code. The current work RVU for this code is less than 54100 *Biopsy of penis* (work RVU = 1.90), however, the structure of 56605 allows additional reporting when more than one vulvar lesion is biopsied, but the penile code may only be reported once, regardless of the number of biopsies.

The RUC recommends 1.10 (no change) for code 56605.

56810 Perineoplasty, repair of perineum, nonobstetrical (separate procedure)

The specialty stated that this service may indeed be undervalued, however perineoplasty is performed so rarely as a separate procedure that it would be very difficult to obtain valid survey data. This code is frequently performed in as a component of pelvic reconstruction and repair codes. The specialty is currently considering CPT revisions to this family of codes and would prefer to review this issue at this time.

The RUC recommends 1.43 (no change) for code 56810.

58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)

The RUC reviewed survey data from 58 obstetricians and gynecologists and determined that this code is, indeed, undervalued. The RUC compared this code to CPT code 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU = 1.57) and determined that these two service are similar in terms of time and intensity. The RUC also agreed that 58100 is more work than the reference procedure 57505 *Endocervial curettage* (work RVU = 1.14).

The RUC recommends a work relative value of 1.53 for code 58100.

Practice Expense:

The RUC is also recommending refinements to the direct practice expense inputs for code 58100. The RUC adjusted the clinical staff time submitted by the specialty society, eliminating duplication in time between activities. The clinical staff time, medical supplies, and equipment are listed in a recommendation form.

Screening Mammography (Tab X)
Presenter: James Borgstede, MD, American College of Radiology

HCFA had requested that the RUC review this code and provide work relative value recommendations and direct practice expense input recommendations. HCFA must place this service on the Medicare Physician Payment Schedule by January 1, 2002. The specialty had indicated, in a memo, that it would not be able to present information to the RUC at the April 2001 meeting. The RUC will place this item on its agenda for the September 2001 meeting.

XIII. Practice Expense Advisory Committee (PEAC) Report

Doctor Bill Moran presented the PEAC report to the RUC. Doctor Moran highlighted the work of the PEAC and the recommendations for the RUC developed during the February and March, 2001 meetings. The RUC accepted the PEAC recommendations on the direct inputs of 183 codes. The RUC also accepted the PEAC recommendation for the facility setting only for an additional 937 codes with global periods of ZZZ, XXX, and 000. The PEAC also made specific recommendations for the discharge day management activities.

The RUC accepted the following recommendation:

- **The PEAC recommends that 6 minutes of clinical staff time for an RN/LPN/MA blend be applied to code 99238 and 9 minutes be applied to 99239. Additionally, whenever these codes are included in a surgical procedure global period, the times should be added to the clinical labor totals.**

The PEAC has been attempting to develop a standard pre-service time for codes with global periods of 90 days. The PEAC developed a standard pre-service time of 60 minutes for the out of office setting and 35 minutes for the office setting to be applied to all codes with 90 day global periods after one year. During the next year, a workgroup will develop criteria for justifying increases or decreases in the pre-service standards. Specialties will then present recommendations for those codes with pre-service times that differ from the standard..

The RUC approved the following recommendations:

- **The pre-service standard clinical staff time of 60 minutes and the post-service office visit time calculation methodology will be applied to all codes with a 90 day global period, with a one year delay to allow specialty societies the opportunity to identify codes that deviate from the pre-service standard and bring these codes to the PEAC for refinement.**

- **Apply the approved E/M clinical staff times to the number and level of visits currently assigned to each code either by HCFA based on RUC data, or if not available, Harvard data.**

The PEAC continues to standardize inputs to simplify refinement and in addition to continuing to examine the pre-service time standards for the 90 day global period, A PEAC workgroup will attempt to develop standard pre-service times for 000 and 10 day global periods. In addition, they will examine standardization of certain staff activities for in office procedures. Another workgroup will examine the coordination of care issue as well as the incremental time to be attributed to providing a chaperone for certain codes. The workgroups continue the PEAC's efforts to streamline the review process.

The PEAC has established a process for selecting codes for review. The PEAC recommends that each specialty refine the practice expense data for the specialty's 10 highest volume codes as well as all codes within the same family as the top ten codes. Specialties will determine the composition of the code families. This will allow the PEAC to review those high volume codes and have the greatest impact while preventing the creation of anomalies by examining families of codes.

The RUC accepted the following recommendation:

- **The PEAC recommends that each specialty refine the practice expense data for the specialty's 10 highest volume codes, as well as all codes within the same family as the top ten codes. Specialties will determine the composition of the code families.**

During the March PEAC meeting, the PEAC held an election for the three rotating seats. Two internal medicine seats as well as one "any other" seat was up for election. The PEAC elected the following positions for the PEAC rotating seats:
Internal Medicine:
Ronald Kaufman, MD -- American College of Rheumatology (ACRh)
Charles H. Weissman, MD -- American Society of Clinical Oncology (ASCO)

"Any Other:"
Susan Spires, MD -- American Society of Cytopathology (ASC)

The RUC accepted Doctor Moran's report and thanked him for the progress that has been made over the past year and his efforts in refining the data HCFA utilizes in the calculation of practice expense relative values.

XIV. **Request for Reconsideration – American Society of Breast Surgeons**

An ad hoc facilitation committee (Doctors Whitten (Chair), Blankenship, Gee, Massanari, and Zwolak) met to review a request from the American Society of Breast Surgeons to reconsider the RUC's work relative value recommendations for CPT codes 19102 *Biopsy of breast; percutaneous, needle core, using imaging guidance* and 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance*. Doctor Whitten reported that the committee carefully reviewed and followed the Appeals Process for Reconsideration of RUC Recommendation, which is listed on page 12, under Tab M in the RUC's *Structure and Functions* document.

Doctor Whitten explained that the focus was specifically on the issues encountered in the RUC Process that would potentially justify reconsideration of these relative values. While members of the committee clearly felt that some of the concerns raised had merit, it was nevertheless the unanimous view of the ad hoc committee that these concerns did not rise to the level of justifying reconsideration.

The ad hoc committee recommended that the work relative values for codes 19102 and 19103 not be reconsidered. **The RUC approved this report.**

XV. **RUC Health Care Professionals Advisory Committee (HCPAC) Review Board Report**

Don Williamson, OD reported that the RUC HCPAC had met on Wednesday, April 25. Dr. Williamson indicated that he had been re-elected as Co-Chair of the HCPAC Review Board. Eileen Sullivan-Marx, PhD, RN has been re-elected to the Alternate Co-Chair position. Dr. Williamson also informed the RUC that the HCPAC Review Board had reviewed several new and revised codes, including gait and motion studies, active wound management, and health & behavior assessment. The Review Board also reviewed PEAC recommendations for services performed by non-MD/DOs.

The RUC HCPAC Review Board report was filed and is attached to these minutes.

XVI. **Anesthesia Facilitation Committee Report**

Doctor Mayer presented the results of the Anesthesia workgroup, which is the third RUC workgroup assigned to evaluate the ASA's five-year review submission. Since the last RUC meeting the workgroup met via conference call as well as each day during the current RUC meeting. The workgroup attempted to overcome the fundamental differences between the ASA payment system and the RBRVS. One of the major differences is the treatment of physician time where in the anesthesia payment system, part of the payment is based on actual time spent. Under Medicare physician payment and the RBRVS, the payment is based on a typical time and if a procedure takes longer than the typical time, the physician is at risk in terms of being under compensated for time spent. The second fundamental issue that the workgroup considered in its analysis was that there is not a one-to-one relationship between the ASA codes and other CPT procedure codes since one anesthesia code can be used for several procedure codes. Attempting to place the ASA codes on the same scale as the physician payment schedule by breaking the anesthesia services into components and valuing each of the components has formed the basis of the ASA proposal. The workgroup examined these different components and is presenting recommendations for the inputs used in the components. For a full discussion of the workgroup's analysis refer to the attached workgroup report.

<u>IWPUT and Quintiles</u>

The workgroup examined each of the 19 anesthesia codes and at the request of the ASA and HCFA, examined the new ASA data relating to the post induction time period. The workgroup agreed that the five quintiles and the examples associated with each quintile were appropriate. The workgroup also examined the IWPUTs assigned to each quintile and made adjustments to the IWPUTs based on comparisons to E/M codes and critical care services.

The RUC approved the following workgroup recommended intensity factors for the quintiles utilized in the ASA analysis:

Quintile 1	**0.0224**
Quintile 2	**0.031**
Quintile 3	**0.051**
Quintile 4	**0.070**
Quintile 5	**0.085**

Induction Period Procedure

The workgroup examined the crosswalks assigned for the induction period procedures and was uncomfortable with a number of the crosswalks. The workgroup therefore used the times assigned to this time period and then assigned IWPUTs to the different types of induction period procedures. Multiplying the physician time for this activity by the IWPUT would produce the physician work value for this component.

The RUC approved the following workgroup recommended intensity factors for the induction procedures:

Induction of general anesthesia.	**0.067**
Induction of spinal and epidural anesthesia	**0.067**
Induction of regional anesthesia	**0.051 (same as 3rd quintile)**

Outstanding Issues

The workgroup also discussed the reduction in time and value required for the induction period procedure associated with code 00142. In order to account for the fact that the ophthalmologist may actually perform the block, the time included in the induction period had been reduced by the ASA. This reduction was based on the survey results that showed that only half of the surveyed anesthesiologists indicated that they carried out retrobulbar blocks for this procedure. However, the question was raised whether this survey result actually meant that half of the patients undergoing the procedure had the retrobulbar block provided by the anesthesiologist. The workgroup discussed methods for determining the percentage of patients in whom the block is given by the anesthesiologist as opposed to the surgeon. Currently, the only way to determine this percentage is by surveying ophthalmologists to determine the percentage of times that they perform the block rather than the anesthesiologist and the workgroup felt that this issue warranted further examination.

The workgroup discussed various ways to verify the distribution of time among the five quintiles. Questions arose about the assignment of time to the various higher quintile levels during several of the procedures (e.g. coronary bypass, colectomy). Some workgroup members felt that they did not have sufficient expertise to verify the distribution and suggested submitting the distributions of the time in the post-induction period to the RUC for additional multi-specialty review, so that surgeons, in particular, that provide the surgical codes included in

the ASA analysis could verify the distribution of times into the quintiles. One suggestion was to forward the quintile time distribution to surgical specialties for their comment prior to the next workgroup meeting in September.

Also, the workgroup has examined the extrapolation issue and discussed to what extent the results of examining the 19 ASA codes could be extrapolated to the remainder of the anesthesia payment schedule. The workgroup remained concerned about extrapolating the results of the analysis of the 19 codes across the remainder of the ASA codes and therefore did not have a recommendation on how to extrapolate the results.

Discussion

Most of the discussion by RUC members agreed with the ultimate outcome of the workgroup recommendations. A number of RUC members questioned what specifically the workgroup was recommending if it was unable to agree on extrapolating the results. Doctor Mayer clarified that the workgroup only reviewed the 19 anesthesia codes and developed values (contingent on the issues discussed above) to give an indication whether or not the anesthesia codes were undervalued. Since the workgroup had several unresolved issues, it was not comfortable with extrapolating the results. Since the workgroup was not recommending extrapolation at this time the HCFA representatives stated that without a RUC recommendation to extrapolate and applying the results to the anesthesia conversion factor, HCFA is not sure what particular action it can take in response to the RUC recommendation. One option HCFA might consider would be establish a separate conversion factor for these 19 anesthesia codes. Doctor Mayer reiterated that the workgroup developed the recommendation for only the 19 codes and was still not comfortable with extrapolating the results due to a number of methodological concerns that have been previously discussed by the RUC and previous workgroups. The workgroup considered this a work in progress to get a sense of under and overvaluation for the 19 codes presented and will continue to examine the unresolved issues.

A number of other RUC members questioned why there was a fundamental difference been the ASA payment system and the rest of the physician payment schedule. Specifically, the ability of anesthesiologists to bill for time is significantly different from surgeons who are at risk for procedures that are longer than the typical time. Doctor Mayer explained that the use of actual time in the anesthesia reimbursement formula and also the range of procedure codes assigned to each anesthesia code, were two reasons why the workgroup was uncomfortable with extrapolating these results since these factors limited the results of the analysis.

Several RUC members stated that the workgroup's work should be viewed as the first step in converting the ASA to the RBRVS scale and that this issue should be further explored by the RUC. Doctors Hoehn and Mayer stressed that the

workgroup recommendation should be viewed as a work in progress that will allow further examination of the unresolved issues.

Conclusion

The RUC accepted the following recommendation:

RUC recommends acceptance of the building block work values of the 19 codes which the RUC evaluated with the provision that additional review will occur of code 00142 to determine the frequency that anesthesiologists provide the retrobulbar block for this code and that review of the distribution of post induction time among the various quintiles would be reviewed as outlined above. The RUC did not come to agreement on extrapolating the results to the remainder of the ASA codes.

The full report of the Anesthesia workgroup is attached to these minutes.

XVII. **Other Issues**

Presentation by Ted Lewers, MD, Chair of the AMA Board of Trustees

On Friday, April 27, Doctor Donald Theodore "Ted" Lewers, Chair, Board of Trustees, American Medical Association met with the RUC at their invitation. Doctor Lewers congratulated the RUC on ten years of service to organized medicine. He thanked the committee for all of the volunteer work and for the high rate of success, noting the 90%+ acceptance rates from HCFA each year. He stated that the individuals participating on the RUC had performed a great service to all physicians in America.

The RUC had specifically asked Doctor Lewers to provide an update on the AMA's activities regarding the Socioeconomic Monitoring Survey (SMS). He explained that the AMA had no choice but to cut the survey during the 2000 round of budget cuts, as it was estimated that the survey would have cost approximately one million to conduct. Doctor Lewers announced that the AMA had been studying alternatives to the SMS and has created a new survey, the Patient Care Physician Survey (PCPS) to be initiated in 2001. The AMA has retained the Gallop Organization to conduct the survey. The PCPS will be conducted every two years and will include a mixture of mail and phone surveys. The AMA will fund a survey to include 3,300 respondents and will include limited practice expense questions (hours worked, physician payroll, professional liability, and total expense). Doctor Lewers explained that the AMA will be working to conduct practice level surveys every other year, beginning with a pilot study in 2002.

RUC members asked if the AMA planned to solicit input from the RUC on the practice expense questions. Doctor Lewers indicated that the AMA welcomes the

input of the RUC and noted that Sara Thran of the AMA would be the lead staff person on this issue who would work with the RUC as the new practice level survey is developed.

A RUC member also queried Doctor Lewers on the activities of the Private Sector Advocacy group at the AMA. Doctor Lewers explained that he was very excited about all of the work that this group is doing as they are changing the dynamics in private healthcare. He also explained that AMA leadership will be meeting with leaders of U.S. corporations and business coalitions to discuss the future of healthcare in the U.S.. Doctor Lewers was provided with a memorandum regarding issues many physicians are facing with coding edits and non-recognition of CPT modifier –25. He noted that he would provide the Private Sector Advocacy with a copy of this memo as they have also been involved in this issue.

Doctor Hoehn thanked Doctor Lewers for his presentation and for providing the RUC with the opportunity to provide further input on the practice level survey as it is developed.

Practice Expense Subcommittee Review of Physician Time for ESRD Services

Doctor John Gage reported that the Practice Expense Subcommittee had convened to discuss to address a specific question that HCFA raised in reviewing the physician time file submitted by the RUC. HCFA was concerned that the physician time for ESRD services should be evaluated. The Practice Expense Subcommittee reviewed the prior RUC recommendations on this issue and met with a representative of the Renal Physicians Association, who is in agreement with the recommendations of the subcommittee. The RUC approved the following recommendations:

- **The RUC recommends that HCFA not use the RUC times previously submitted in March 2001 for ERSD services (codes 90918 through 90925).**

- **The RUC recommends 182 minutes of physician time for code 90921 and 6 minutes for code 90925.**

- **The RUC will continue to review the physician time of the pediatric ERSD services (90918 – 90920, 90922 – 90924)**

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

Critical Care

As noted in the HCFA Update, HCFA staff indicated that the Proposed Rule on the Five-Year Review would include some discussion related to critical care services included in the global period. HCFA is specifically concerned as to whether it is appropriate to include work relative value units related to critical care services in the post-service period of a surgical code with a 090 day global period. In addition, the RUC received a letter from the Critical Care Work Group (American College of Chest Physicians, American Society of Critical Anesthesiologists, American Thoracic Society, the National Association for Medical Direction of Respiratory Care, and the Society of Critical Care Medicine) requesting that the RUC review the issue of critical care in the global period at the September RUC meeting.

Several RUC members noted that critical care services, when performed by surgeons, have always been bundled into the surgical global payment (except for the allowed separate reporting for burn and trauma patients). The RUC has refined its survey to more specifically capture the time increments in the global period and the critical care codes have been listed in the RUC survey instrument. RUC members noted that they did not understand why this issue had surfaced, as the reference to the evaluation and management codes in the global period are only used as a proxy to estimate this time and work. It was also noted that it may be common for more than one physician to be performing critical care services to the same patient on the same date.

The RUC agreed that it would relay these comments to HCFA during the comment period on the Proposed Rule on the Five-Year Review. This issue has also been referred to the Research Subcommittee for discussion at the September RUC meeting.

RUC Workgroup to Review Services Reported with Multiple Codes

At recent RUC meetings, the RUC has become concerned with understanding the coding and payment issues for services that are reported with multiple CPT codes. Several RUC members had commented that the RUC should form a workgroup to study this issue. Doctor Hoehn has appointed the following individuals to a new workgroup to begin to review these issues:

Barbara Levy, MD, Chair
James Blankenship, MD
James Borgstede, MD
John Derr, Jr, MD
Lee Eisenberg, MD
J. Leonard Lichtenfeld, MD
Gregaroy Przbylski, MD
Bruce Sigsbee, MD

This workgroup will meet via conference call prior to a face-to-face meeting at the September RUC meeting.

Typical Patient/Service

Doctor Charles Koopmann raised the issue of whether it continues to be appropriate to use the "typical" patient in reviewing both the work relative value and the practice expense inputs, or whether the RUC should consider utilizing blended data in evaluating services. Doctor Hoehn referred this issue to the Research Subcommittee for review.

CPT Coding Changes Proposed by Individuals Not Affiliated with Specialty Societies

The RUC noted that several new and revised codes reviewed at this meeting and previous meetings were not initiated by medical specialty societies. Doctor Hoehn has referred this issue to the Administrative Subcommittee to review the process to be utilized when a coding proposal is initiated without support of a specialty society and the specialty, therefore, has no interest in conducting a survey or developing relative value recommendations.

The RUC meeting concluded on Sunday, April 29, 2001 at noon.

RUC Health Care Professionals Advisory Committee Review Board
April 25, 2001

The RUC HCPAC Review Board met on Wednesday, April 25, 2001. The Review Board re-elected the Co-Chair and Alternate Co-Chair; reviewed issues related to Gait and Motion Studies; Active Wound Care Management; Health Behavior and Assessment. The committee also reviewed the PEAC recommendations for codes submitted by non-MD/DO specialties. The Review Board welcomed a new member, Karen Smith, MS, RD, LD, FADA of the American Dietetic Association.

Election of Co-Chair and Alternate Co-Chair

The Review Board has elected Don E. Williamson, OD as the Co-Chair of the HCPAC and to serve as the representative to the RUC. Eileen Sullivan-Marx, PhD, RN was elected to the Alternate Co-Chair position.

Gait and Motion Studies

The Review Board considered a letter and presentation from the American Physical Therapy Association (APTA) that explained that the gait and motion studies (XX1-XX4 only) were not surveyed for this meeting due to a mis-understanding regarding the vignettes. APTA noted that the RUC review of the physician interpretation code (XX5) would be helpful in clarifying that the interpretation work should be in this code (XX5) and XX1-XX4 should describe the performance of the tests.

The Review Board recommends that these codes (XX1-XX4) be carrier priced for 2002 and survey data be presented to the HCPAC in September 2001.

Active Wound Management

The Review Board had approved work relative value units for the active wound management codes at the February 2001 meeting. The APTA presented practice expense data for codes 97601 and 97602 at this meeting. The Review Board made adjustments to the clinical staff and held extensive discussions regarding the supplies and equipment. Modified lists of direct practice expense inputs will be forwarded to HCFA.

Health Behavior and Assessment

The HCPAC Review Board reviewed the Health Behavior and Assessment codes and approved the work relative value recommendations for all services (with the exception of the group code – 909X4) at the February 2001 meeting. The American Psychological Association and the National Association of Social Workers presented a recommendation for the group code. The Review Board agreed that the code should be between 99141 Preventive Medicine group, medicine counseling, 30 minutes (work rvu = 0.15; .08 per

15 minutes) and 90853 Group psychotherapy (work rvu = 0.59; .15 per 15 minutes) and recommends the following.

909X4 (G4) Health and behavior intervention, each 15 minutes, group (2 or more patients) .10 Work RVU

The Review Board noted that the typical group size of 6-8 patients is consistent between these codes.

The Review Board also approved a supply package (valued at 37¢) for these codes. There are no inputs for clinical staff or equipment.

PEAC Recommendations

The PEAC submitted practice expense inputs for 48 codes to the Review Board. The AAOS had requested that the Review Board refer the practice expense inputs for 11043 & 11044 (out-of-office setting only) back to the PEAC to obtain input from orthopaedic surgery, plastic surgery, and general surgery. With the exception of these two codes, the Review Board approved the PEAC recommendations.

AMA/SPECIALTY SOCITY RVS UPDATE COMMITEEE
FIVE-YEAR REVIEW RECOMMENDATIONS

Anesthesia—May, 2001

Background
During the previous conference call, the RUC was asked by ASA and HCFA to attempt to develop a recommendation on the values for the 19 ASA codes. The RUC members discussed what the possible outcomes of only examining the 19 codes without agreeing on an extrapolation methodology. Paul Rudolf, HCFA explained that HCFA would like the RUC to reach a recommendation on the values of the 19 codes and would also consider a RUC recommendation on the appropriateness of extrapolating these results. If the RUC were to recommendation that it was not possible to extrapolate the results, then HCFA would examine methodologies for extrapolating. The RUC members reiterated their concerns with extrapolating the result at this time due to insufficient methodology for doing so.

Concerns With Extrapolating Results
The RUC discussed the problem of equating the two different scales of RVUs. It was also noted that one anesthesia code (incorporates) a significant number of procedure codes and that there were significant variations in the time involved in the various procedures covered by a single anesthesia codes (see Dr. Florin's letter-attached). The effect of these variations in time and the representativeness of the procedure code selected for the vignette for the entire ranges of codes covered by the single anesthesia code were recognized as likely limitations on the ability to extrapolate the results developed by the RUC beyond the 19 procedure codes evaluated by the RUC. The RUC discussed the need to create a one to one relationship between ASA codes and CPT codes by collecting average anesthesia time for each CPT procedure code. It was noted that additional data would need to be collected in order to place both sets of codes on the same scale and compare the relative work values. Several RUC members stated that such work would not be productive since the underlying differences in the two systems have not been resolved. In particular, the fact that the anesthesia reimbursement system provides payments based, in part, on the time for each individual patient undergoing a procedure, while essentially all procedure codes are reimbursed based the average time for all patients undergoing a procedure was thought to be a fundamental problem in reconciling the two systems.

Notwithstanding these conceptual hurdles, the RUC agreed to proceed with attempting to address the comparability of various components within the anesthesia services with services provided by other physician groups.

Post Induction Time Period
The RUC members discussed the calculations used to develop relative values for the intra-service period, and the use of IWPUT calculations. Doctor Hannenberg reiterated the methodology the ASA employed as described in his memo to the RUC dated April 19, 2001.

The RUC agreed that the five quintiles and the examples associated with each quintile was appropriate. The RUC then discussed the IWPUTs associated with each level and the ASA methodology for assigning the IWPUTs. As explained in the ASA memo, the ASA rationale for the IWPUT's for each intensity level was as follows:

The intensity value for level 1 was determined to be below E&M (0.031) but was felt to be higher than surgical prep/drape/positioning (0.0224). A value of 0.026, 15% below E&M intensity was chosen for this quintile. Level 2 involves physician work associated with rapid evaluation of changing patient

physiology or surgical stress and acute intervention to correct non-life threatening conditions. Our judgment was that this work should be associated with an intensity value slightly higher than E&M and we assigned it a value 15% above 0.031, at 0.036.

Intensity Assigned to Each Quintile

The RUC focussed its discussions on the IWPUTs assigned to each of the five quintiles. For levels 3, 4, and 5 the RUC agreed with the levels assigned by ASA recognizing that these represent the more intense periods during the intra-operative period and constitute 28% of the post-induction time for these 19 codes. The ASA described the activities in these three levels as follows:

> Intensity level 3 involves more complex patient management and riskier interventions. The illustrations cite induced hypotension for intracranial aneurysm clipping, management of severe hypertension and the extubation-related activities including assessment and reversal of neuromuscular block and evaluation of respiratory effort and airway patency. These activities require the administration of multiple potent intravenous agents and very critical decision making. For example, blood pressure and neuromuscular blockade must be maintained precisely at the desired levels during aneurysm clipping or the surgical result may be severely compromised. A patient extubated prematurely will become hypoxic during transport. The intensity level for these activities was judged to fall toward the lower end of critical care services and a value of 0.051 was selected.
>
> The next highest quintile is described by evaluation and management of cardiovascular crises or the intentional collapse of a lung for thoracic surgery. These activities were judged to be slightly higher than the overall intensity value associated with critical care. Most patients receiving critical care services are not in the midst of acute cardiovascular collapse nor have they acutely lost half their lung capacity. Thus, a small increment over the general critical care intensity of 0.067 was chosen: 0.070.

> The highest quintile is characterized by multiple simultaneous interventions required to manage immediately life-threatening catastrophes or multiple simultaneous severe physiologic derangements such as associated with separation from cardiopulmonary bypass or aortic clamping and unclamping. An intensity value at the high end of those found in the fee schedule, 0.085, was chosen for this quintile.

The RUC recommends an intensity for quintiles 3, 4 and 5 as follows:
Quintile 3 .051; Quintile 4 .070; Quintile 5 .085

The intensities for the first two quintiles were discussed in detail and were compared to the intensity for E/M services of .031 and that of pre operative evaluation and patient positioning, which is .0224. The ASA had proposed that the Intensity for quintile 1 should be 15% less than E/M intensity and above the pre operative evaluation intensity of .0224. The RUC had considerable discussion on this issue and compared the level of decision making that occurs with E/M codes and the pre-operative evaluation as well as the activities that occurs during quintile 1. The RUC agreed that the intensity as measured by the level of decision making in the first quintile is equivalent to the .0224 level associated with pre pre-operative evaluation and positioning the patient.

The RUC then discussed the intensity for quintile 2 and focused on comparing the intensity of E/M codes. The ASA stressed that the level of decision making with this quintile was 15% above E/M intensity due to the work associated with rapid evaluation of changing patient physiology or surgical stress and acute intervention to correct non-life threatening conditions. The RUC concluded that the level of decision making would be equivalent to E/M intensity and agreed, although it was not unanimous, the intensity for the second quintile is .031.

The RUC recommends an intensity level of .0224 for quintile 1 and an intensity of .031 for quintile 2.

Induction Period Procedure
The RUC examined the induction period procedures (IPPs) selected and agreed with the original RUC recommendations, however, the RUC had considerable discussion regarding the intubation performed by an anesthesiologist and the reference service of emergency intubation, code 31500. The ASA explained that the intensity is actually greater than the emergency intubation and the discussion centered on comparing the intensity of intubation to critical care intensity of .067 and the intensity of .051 selected for the third quintile. The ASA explained that the IPP is more than just the placement of the tube but all of the decision making associated with intubation such as drug choice. Also, the skill necessary for proper intubation is substantial. **Therefore, the RUC recommends using an intensity of .067 for the time period of the induction of general anesthesia.**

The RUC also examined the intensity for spinal and epidural induction procedures. Initially the RUC compared these procedures to spinal injection procedures but focused on the similarities between general anesthesia and spinal anesthesia. The RUC concluded that regardless of the method of anesthesia, the risk of adverse outcomes and skill needed is similar. **Given the inherent risks in the induction, the RUC recommends that and intensity of .067 also be applied for spinal and epidural anesthesia.**

Code 01844, one of the 19 ASA codes under review was characterized as utilizing a regional IPP and the RUC concluded that the intensity of regional anesthesia was different from the other types of IPPs. The RUC agreed that there was less risk inherent in this type of IPP, however, in general the skill required warranted a relatively high intensity value. **The RUC recommends that the IWPUT of .051 assigned to the 3rd quintile was appropriate for the time involved in the induction of regional anesthesia.**

The RUC also discussed the reduction in time and value for the IPP for code 00142. In order to account for the fact that the ophthalmologist may actually perform the block, the time included in the induction period had been reduced by the ASA. This reduction was based on the survey results which showed that half of the surveyed anesthesiologists indicated that they carried out retrobulbar blocks. However, the question was raised whether this survey result actually meant that half of the patients undergoing the procedure had the retrobulbar block provided by the anesthesiologist. The RUC discussed methods for determining the percentage of patients in whom the block is given by the anesthesiologist as opposed to the surgeon. Currently, the only way to determine this percentage is by surveying ophthalmologists to determine the percentage of times that they perform the block rather than the anesthesiologist.

Pre and Post Service Work

The RUC reviewed the pre-service crosswalks and discussed whether it was appropriate to include pre and post service work in the crosswalks. The ASA explained that these codes do include pre and post-service work and agreed to the values already recommended by the original RUC for the pre-service crosswalks. The RUC also agreed with the original RUC crosswalks for the post-service period since the RUC time for these crosswalks did not include pre-service time and therefore did not double count physician work.

Time Distribution

The RUC discussed various ways to verify the distribution of time among the five quintiles. Questions arose about the assignment of time to the various higher quintile levels during several of the procedures (e.g. coronary bypass, colectomy). Some RUC members felt that they did not have sufficient expertise to verify the distribution and suggested submitting the distributions of the time in the post-induction period to the RUC for additional multi-specialty review, so that surgeons, in particular, that provide the

surgical codes included in the ASA analysis could verify the distribution of times into the quintiles.

Conclusion

The RUC recommends acceptance of the building block work values of the 19 codes which the RUC evaluated with the provision that additional review will occur of code 00142 to determine the frequency that anesthesiologists provide the retrobulbar block for this code and that review of the distribution of post induction time among the various quintiles would be reviewed as outlined above. The RUC did not come to agreement on extrapolating the results to the remainder of the ASA codes.

Practice Expense Subcommittee Report
Approved at the April 2001 RUC Meeting

The Practice Expense Subcommittee met to develop a recommendation for physician time for dialysis codes. The following subcommittee members participated: Doctors Gage (Chair), Lichtenfeld, Mayer, McCaffree, Plummer, and Walter Smoski, PhD. Doctor Florin also participated in the meeting. Doctor Emil Paganini represented the Renal Physicians Association.

As a result of the HCFA review of the RUC physician time submission, HCFA questioned the RUC time submitted for codes 90921 through 90925. It was discovered that the original summary of recommendation form was altered to not include the pre and post-service time for the code, and therefore the time submitted to HCFA was incorrect. As a result, the RUC met on short notice to clarify the RUC recommendation of physician time for these codes. After discussing the RUC recommendation on work relative values from 1994, the RUC agreed to use the same building-block methodology for developing physician time as was used for developing the work relative value. For code 90921, the RUC utilized the following building block methodology to develop the work RVU:

Calculation of RUC RVW Recommendation for code 90921

FOR HEMODIALYSIS

Total number of dialysis per month	13	(Standard – patient receives dialysis 3 times per week)
Total number of visits per month	6.9	(Mendenhall = 6.8/1991 RPA Survey = 6.9)
Visits in office	1.2	(1991 RPA Survey)
Visits in dialysis unit	5.7	(1991 RPA Survey)
Interventions in dialysis	3.3	(1991 RPA Survey)

Translation to Equivalent Work Values

Face to Face:

99215 (1.51) X 1.2	1.812	(1991 RPA Survey and 1994 RUC Survey)
99213 (0.55) X 3.3	1.815	(3.3 interventions per month – 1991 RPA Survey)
99212 (0.38) X 2.4	0.912	(remaining dialysis visits per month)
Total Visits 6.9		

Care Plan Oversight: 99375 (1.06) X 1 1.060

Hemodialysis Relative Work Value 5.599

FOR PERITONEAL DIALYSIS:

47% of hemodialysis (5.599 X .47) 2.632 (Ratio used by RUC and CMD panel in previous calculations)

Blend of Hemodialysis (82% of Patients) and Peritoneal Dialysis (18% of Patients)
(0.82 X 5.599) + (0.18 X 2.632) = **5.06**

The RUC agreed that the physician time should mirror this building block methodology and used the following calculation that utilized the full RUC times for the 1.2 office visits and the care plan oversight, but agreed that only the face to face time should be used for the remaining E/M visits. The face to face time was used rather than the full time because the committee and the Renal Physicians Association representative agreed that including all of the pre and post service time for these visits would lead to double counting of pre and post-service time. Using the same building block methodology, a total of 182 minutes for code 90921 calculated as follows.

99215 1.2 X 59=71
99213 3.3 X 15=49.5
99212 2.4 X 10=24
99375 =57 minutes
total hemodialysis time = 201.5
total peritoneal dialysis = .47X201.5=94.7

(.82 X201.5) + (0.18X94.7) = **182 minutes total time**

Since the work value for 90925 was developed by taking 1/30 of the value of 90921, the RUC aged to use the same methodology for calculating physician time and recommends 6 minutes for 90925.

The RUC recognized that recommending this time for code 90921 creates a rank order anomaly within the time currently used for this family of codes, but at this time the RUC recommends that HCFA review the times that it is currently using for this family to remove any possible rank orders.

- **The RUC recommends that HCFA not use the RUC times previously submitted in March 2001 for ERSD services (codes 90918 through 90925).**

- **The RUC recommends 182 minutes of physician time for code 90921 and 6 minutes for code 90925.**

- **The RUC will continue to review the physician time of the pediatric ERSD services (90918 – 90920, 90922 – 90924)**

AMA/Specialty Society Update Process
RUC Summary of Recommendation
010 or 090 Day Global Periods
Out-Of-Office Direct Inputs

Sample Size: **consensus** Response Rate: (%): **n/a** Global Period: **10-day**

Tracking Number: **F5** Reference Code 1_____ Reference Code 2_____

Geographic Practice Setting %: Rural____ Suburban_____ Urban_____

Type of Practice %: _____Solo Practice
_____Single Specialty Group
_____Multispecialty Group
_____Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Consensus on direct inputs for 4737X5 was reached via a conference call with representation from ACR's Practice Expense Committee and SCVIR's Economics Committee. (SCVIR's Economics Committee serves as its RUC/Practice Expense Committee.) Both the ACR's Practice Committee and SCVIR's Economics Committee consist of broad representation of geographic regions and practice types.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Completes pre-service diagnostic and referral forms
- Coordinates pre-surgery services and scheduling
- Obtains necessary medical records
- Provides education and obtains consent

Intra-Service Clinical Labor Activities:

- Coordinates post procedural care

Post-Service Clinical Labor Activities:

- Conducts phone calls and calls in prescriptions
- Coordinates home and outpatient care

HCFA's Staff Type Code***	Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge**	Number of Office Visits	Total Time of Office Visits	Cost Estimate and Source (if applicable)
1033	RN	60 min	~~5~~ **0** min	~~20~~ **7** min	~~11~~ **7** min	1-99212	~~10~~ **27** min	

*By staff in the physician's office during the service period.
**Excluding Time of Office Visits
*** From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11107	Patient gown	1	Item	
11111	Exam table paper	7	Foot	
11112	Pillow case	1	Item	
11302	Non-sterile gloves	2	Pair	
11509	Temp probe cover	1	Item	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11001	Exam table	4	20	40	

* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, please provide full description, estimated cost, and cost source.

TYPE OF SERVICE: Surgical Procedures
010 and 090 Global Periods

SITE OF SERVICE: OUT-OF-OFFICE

Clinical Services	Minutes	Staff Type – Circle
Pre-Service Period *Start: Following visit when decision for surgery or procedure made*		
Complete pre-service diagnostic & referral forms	5 minutes	RN, LPN, MA, Other _____
Coordinate pre-surgery services	20 minutes	RN, LPN, MA, Other _____
Schedule space and equipment in facility	8 minutes	RN, LPN, MA, Other _____
Office visit before surgery/procedure Review test and exam results	_____	RN, LPN, MA, Other _____
Provide pre-service education/obtain consent	20 minutes	RN, LPN, MA, Other _____
Follow-up phone calls & prescriptions	7 minutes	RN, LPN, MA, Other _____
Other Activity (please specify) _____	_____	RN, LPN, MA, Other _____
End: When patient enters hospital for surgery/procedure		
Service Period *Start: Patient admitted to hospital for surgery/procedure* *Pre-service services*		
Review charts		RN, LPN, MA, Other _____
Greet patient and provide gowning		RN, LPN, MA, Other _____
Obtain vital signs		RN, LPN, MA, Other _____
Provide pre-service education/obtain consent		RN, LPN, MA, Other _____
Prepare room, equipment, supplies		RN, LPN, MA, Other _____
Prepare and position patient/ monitor patient/ set up IV		RN, LPN, MA, Other _____
Sedate/apply anesthesia		RN, LPN, MA, Other _____
Intra-service		
Assist physician in performing surgery/procedure		RN, LPN, MA, Other _____

Post-service

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MA, Other _____
Clean room/equipment by physician staff	_____	RN, LPN, MA, Other _____
Assist with ICU or hospital visits	_____	RN, LPN, MA, Other _____
Total Number of ICU visits	_____	
Total Number of hospital visits	~~1~~ **0**	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MA, Other _____
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MA, Other _____
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	~~5~~ **0** minutes	RN, LPN, MA, Other _____
Coordination of care by staff in office	~~20~~ **7** minutes	RN, LPN, MA, Other _____
Other Activity (please specify)		
_____	_____	RN, LPN, MA, Other _____

End: Patient discharge from hospital

Post-Service Period
Start: Patient discharge from hospital

Conduct phone calls/call in prescriptions	~~11~~ **7** minutes	RN, LPN, MA, Other _____
Office visits Greet patient, escort to room Provide gowning Interval history & vital signs & chart Assemble previous test reports/results Assist physician during exam Assist with dressings, wound care, suture removal Prepare Dx test, prescription forms Post service education, instruction, counseling Clean room/equip, check supplies Coordinate home or outpatient care	**A** ~~10~~ **27** minutes	RN, LPN, MA, Other _____
List total number of office visits	**B 1 - 99212**	
Total office visit time (A * B)	~~10~~ **27** minutes	
Conduct phone calls between office visits	_____	RN, LPN, MA, Other _____
Other Activity (please specify)		
	_____	RN, LPN, MA, Other _____

End: With last office visit before end of global period

ASA Five-Year Review Workgroup Recommendation

The following workgroup members met throughout the April RUC meeting to discuss the ASA five-year review recommendation: Doctors John E. Mayer, (Chair), John Derr, Jr., Robert Florin, Alexander Hannenberg, Charles Koopman, J. Leonard Lichtenfeld, James Moorefield, Sandra Reed, William Rich, Bruce Sigsbee, and Richard Whitten.

Background

Doctor Mayer reiterated the short term goal of the workgroup is to evaluate the ASA five-year review recommendation and the long term goal is to examine possibility of placing the ASA codes on the same scale as the RBRVS. The short term goal was viewed as providing to HCFA a rationale upon which they could consider any changes in the anesthesia reimbursement which they provide. In terms of evaluating the five year review recommendation, the two issues that the workgroup had previously identified relate to valuing the post induction work and also considering whether extrapolation of the results of an analysis of the 19 ASA codes to the remainder of the anesthesia fee schedule was possible.

During the previous conference call, the workgroup was asked by ASA and HCFA to attempt to develop a recommendation on the values for the 19 ASA codes. The workgroup members discussed what the possible outcomes of only examining the 19 codes without agreeing on an extrapolation methodology. Paul Rudolf, HCFA explained that HCFA would like the RUC to reach a recommendation on the values of the 19 codes and would also consider a RUC recommendation on the appropriateness of extrapolating these results. If the RUC were to recommendation that it was not possible to extrapolate the results, then HCFA would examine methodologies for extrapolating. The workgroup members reiterated their concerns with extrapolating the result at this time due to insufficient methodology for doing so.

Concerns With Extrapolating Results

The group discussed the problem of equating the two different scales of RVUs. It was also noted that one anesthesia code (incorporates) a significant number of procedure codes and that there were significant variations in the time involved in the various procedures covered by a single anesthesia codes (see Dr. Florin's letter-attached). The effect of these variations in time and the representativeness of the procedure code selected for the vignette for the entire ranges of codes covered by the single anesthesia code were recognized as likely limitations on the ability to extrapolate the results developed by the workgroup beyond the 19 procedure codes evaluated by the workgroup. The workgroup discussed the need to create a one to one relationship between ASA codes and CPT codes by collecting average anesthesia time for each CPT procedure code. It was noted that additional data would need to be collected in order to place both sets of codes on the same scale and compare the relative work values. Several workgroup members stated that such work would not be productive since the underlying differences in the two systems have not been resolved. In particular, the fact that the anesthesia reimbursement system provides payments based, in part, on the time for each individual patient undergoing a procedure, while essentially all procedure codes are reimbursed based the average time for all patients undergoing a procedure was thought to be a fundamental problem in reconciling the two systems.

Notwithstanding these conceptual hurdles, the group agreed to proceed with attempting to address the comparability of various components within the anesthesia services with services provided by other physician groups.

Post Induction Time Period
The workgroup members discussed the calculations used to develop relative values for the intra-service period, and the use of IWPUT calculations. Doctor Hannenberg reiterated the methodology the ASA employed as described in his memo to the workgroup dated April 19, 2001.

The workgroup agreed that the five quintiles and the examples associated with each quintile was appropriate. The workgroup then discussed the IWPUTs associated with each level and the ASA methodology for assigning the IWPUTs. As explained in the ASA memo, the ASA rationale for the IWPUT's for each intensity level was as follows:

> The intensity value for level 1 was determined to be below E&M (0.031) but was felt to be higher than surgical prep/drape/positioning (0.0224). A value of 0.026, 15% below E&M intensity was chosen for this quintile. Level 2 involves physician work associated with rapid evaluation of changing patient physiology or surgical stress and acute intervention to correct non-life threatening conditions. Our judgment was that this work should be associated with an intensity value slightly higher than E&M and we assigned it a value 15% above 0.031, at 0.036.

Intensity Assigned to Each Quintile
The workgroup focussed its discussions on the IWPUTs assigned to each of the five quintiles. For levels 3, 4, and five the workgroup agreed with the levels assigned by ASA recognizing that these represent the more intense periods during the intra-operative period and constitute 28% of the post-induction time for these 19 codes. The ASA described the activities in these three levels as follows:

> Intensity level 3 involves more complex patient management and riskier interventions. The illustrations cite induced hypotension for intracranial aneurysm clipping, management of severe hypertension and the extubation-related activities including assessment and reversal of neuromuscular block and evaluation of respiratory effort and airway patency. These activities require the administration of multiple potent intravenous agents and very critical decision making. For example, blood pressure and neuromuscular blockade must be maintained precisely at the desired levels during aneurysm clipping or the surgical result may be severely compromised. A patient extubated prematurely will become hypoxic during transport. The intensity level for these activities was judged to fall toward the lower end of critical care services and a value of 0.051 was selected.
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> The next highest quintile is described by evaluation and management of cardiovascular crises or the intentional collapse of a lung for thoracic surgery. These activities were judged to be slightly higher than the overall intensity value associated with critical care. Most patients receiving critical care services are not in the midst of acute cardiovascular collapse nor have they acutely lost half their lung capacity. Thus, a small increment over the general critical care intensity of 0.067 was chosen: 0.070.
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> The highest quintile is characterized by multiple simultaneous interventions required to manage immediately life-threatening catastrophes or multiple simultaneous severe physiologic derangements such as associated with separation from cardiopulmonary bypass or aortic clamping and unclamping. An intensity value at the high end of those found in the fee schedule, 0.085, was chosen for this quintile.

The Workgroup recommends an intensity for quintiles 3, 4 and 5 as follows:
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The intensities for the first two quintiles were discussed in detail and were compared to the intensity for E/M services of .031 and that of pre operative evaluation and patient positioning, which is .0224.

The ASA had proposed that the Intensity for quintile 1 should be 15% less than E/M intensity and above the pre operative evaluation intensity of .0224. The workgroup had considerable discussion on this issue and compared the level of decision making that occurs with E/M codes and the pre-operative evaluation as well as the activities that occurs during quintile 1. The workgroup agreed that the intensity as measured by the level of decision making in the first quintile is equivalent to the .0224 level associated with pre pre-operative evaluation and positioning the patient.

The workgroup then discussed the intensity for quintile 2 and focused on comparing the intensity of E/M codes. The ASA stressed that the level of decision making with this quintile was 15% above E/M intensity due to the work is associated with rapid evaluation of changing patient physiology or surgical stress and acute intervention to correct non-life threatening conditions. The workgroup concluded that the level of decision making would be equivalent to E/M intensity and agreed, although it was not unanimous, the intensity for the second quintile is .031.

The workgroup recommends an intensity level of .0224 for quintile 1 and an intensity of .031 for quintile 2.

Induction Period Procedure

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The workgroup also examined the intensity for spinal and epidural induction procedures. Initially the workgroup compared these procedures to spinal injection procedures but focused on the similarities between general anesthesia and spinal anesthesia. The workgroup concluded that regardless of the method of anesthesia, the risk of adverse outcomes and skill needed is similar. **Given the inherent risks in the induction, the workgroup recommends that and intensity of .067 also be applied for spinal and epidural anesthesia.**

Code 01844, one of the 19 ASA codes under review was characterized as utilizing a regional IPP and the workgroup concluded that the intensity of regional anesthesia was different from the other types of IPPs. The workgroup agreed that there was less risk inherent in this type of IPP, however, in general the skill required warranted a relatively high intensity value. **The workgroup recommends that the IWPUT of .051 assigned to the 3rd quintile was appropriate for the time involved in the induction of regional anesthesia.**

The workgroup also discussed the reduction in time and value for the IPP for code 00142. In order to account for the fact that the ophthalmologist may actually perform the block, the time included in the induction period had been reduced by the ASA. This reduction was based on the survey results which showed that half of the surveyed anesthesiologists indicated that they carried out retrobulbar blocks. However, the question was raised whether this survey result actually meant that half of the patients undergoing the procedure had the retrobulbar block provided by the anesthesiologist. The workgroup discussed methods for determining the percentage of patients in whom the block is given by the anesthesiologist as opposed to the surgeon. Currently, the only way to determine this percentage is by

surveying opthamologists to determine the percentage of times that they perform the block rather than the anesthesiologist.

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Time Distribution
The workgroup discussed various ways to verify the distribution of time among the five quintiles. Questions arose about the assignment of time to the various higher quintile levels during several of the procedures (e.g. coronary bypass, colectomy). Some workgroup members felt that they did not have sufficient expertise to verify the distribution and suggested submitting the distributions of the time in the post-induction period to the RUC for additional multi-specialty review, so that surgeons, in particular, that provide the surgical codes included in the ASA analysis could verify the distribution of times into the quintiles.

Conclusion
The workgroup recommends acceptance of the building block work values of the 19 codes which the group evaluated with the provision that additional review will occur of code 00142 to determine the frequency that anesthesiologists provide the retrobulbar block for this code and that review of the distribution of post induction time among the various quintiles would be reviewed as outlined above. As previously agreed, the workgroup does not recommend extrapolating these results to the remainder of the ASA codes.

Urology Facilitation Committee Results, April 27, 2001

Doctors Rich (Chair), Gee, Koopman, Hannenberg, Levy, Taubman, and Maybry, met at lunch time to discuss the following Urology codes.

5385X ***Transurethral destruction of prostate tissue; by water-induced thermotherapy***
The facilitation committee met during lunch and reviewed several different codes across specialties and found that code 54670, *Suture or repair of testicular injury(WRVU=6.41)* was similar in physician work and time with 30 minutes pre, 60 minutes intra-service, 2 hospital visits and 2.5 99212 office visits in the post op period was a good cross walk for 5385X. 5385X has 15 minutes more pre time but no hospital days and an additional half post op visit. The IWPUT of the 54670 at 0.052 is also similar to the IWPUT of 0.050 for the code under consideration.

When 5385X is compared to the reference code, 53850, there are 30 less minutes of intra-service time for the code under consideration which is 30% less intra-service time than the reference code with an WRVU of 9.45. There is also a difference in pre post time between the codes of the two codes of 30%. If one looks at 2/3 the value of the reference code a value of 6.44 is found which supports the committee cross walk to 54670.

The committee and the AUA concurred that the level of decision making during the intra-service time is less intense for 5385X as compared to the reference 53850 which is reflected in the difference in IWPUT of 0.050 for 5385X as compared to 0.060 for 53850. The committee recommends a WRVU or **6.41**

The practice expense for 5385X was modified to exclude the following:
Tape
Gloves-non-sterile
30 cc syringe
10 cc syringe
Gloves –sterile

53447 ***Removal, and replacement of inflatable urethral/bladder neck sphincter including pump reservoir, and cuff at the same operative session.***
The faciliation committee reviewed several similar procedures, and found that code 36830 *Creation of arteriovenious fistual by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft* was similar in intra-service work with an RVU of 12.00. However, the group believed that there was additional work associated with the hospital visits and office visits with this code. Code 36830 did not involve hospital visits, and only 1 office visit. Code 53447 was reported to have 1 hospital visit day, a discharge day, and 3 office visits. The committee also compared codes 62143 and 42200 as further evidence in supporting a value above 12.00 RVUs. Based on the fact that more physician time and effort was involved in code 53447 than in 36830, the committee recommended the 25th percentile median value of **13.49 RVUs.**

Practice expense for code 53447 passed previously, and there were no adjustments.

534X2 ***Removal, and replacement of inflatable urethral/bladder neck sphincter including pump, resevoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue (Do not report 11040-11043 in addition to 534X2)***
The facilitation committee reviewed the survey results again, and recognized that code 27091- *Removal of hip prosthesis; (separate procedure) complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer* was similar work and intensity as code 534X2. Code 27091 has a work RVU of 13.49 with less intra-service time and no hospital days. The committee reviewed other Orthopeadic codes and found that code 27091 could be used as an initial building block code. The committee then added the RVUs of the hospital visits involved in this code, as well as 30 more minutes of intra-service time at an intensity of .079 to come up with a value of 21.18 RVUs, which is similar to the 75th percentile of the survey. Based on these calculations, and by reviewing similar codes, the faciliation committee recommended the 75th percentile of **21.15 RVUs.**

The practice expense for this code is similar to the code 53447 and there were no adjustments made.
-

Facilitation Committee Meeting – Pediatric Surgery, Vascular Surgery
April 28, 2001

Doctors MaCaffree, Sawchuk, Levy, Topping, Felger, Zwolak, and Bradley discussed these issues during lunch.

Vascular Surgery

35646 – LL2 ***Bypass graft, with other than vein; aortobifemoral***

The facilitation committee extensively reviewed each of the time components of this code. The committee came to a better understanding of the pre-service work involved, and believed it was justified. The intra-service time was considered low, in the opinion of the committee, noting that these patients are highly complex. The post service E/M levels on the specialty's recommendation form was also consistent with other similar 090 global codes. Total time of 602 minutes, the committee felt, was below normal for this level of physician work. In addition, the committee noticed that the Medicare frequency had dropped 25% from 1995 – 1999, which could indicate the patient population may be sicker and more complex. With this understanding the facilitation committee reaffirmed the specialty society's recommendation of the survey median **RVW of 31.00,** believing that the median RVW would avoid anomolies within the family of codes and other codes with similar work. The facilitation committee also reviewed the IWPUT of this code and found it reasonable for this type of service.

3568X1 – LL3 ***Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure) (Use 3568X1 in conjunction with codes 35656, 35666, or 35671)***

3568X2 – LL4 ***Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure) (Use 3568X2 in conjunction with codes 35556, 35566, 35571, 35583, 35585, 35587, 35623, 35656, 35666, 35671)***

The facilitation committee reviewed the work of both LL3 and LL4 and the relativity among their family of codes. The committee decided that these two codes would be more appropriately valued at the 25th percentile of the survey results rather than the specialty recommended survey median RVW. **The facilitation committee recommends survey 25th percentile results of an RVW of 4.05 for LL3 and an RVW of 3.35 for LL4.**

Pediatric Surgery

4412X1 – E1 ***Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis of proximal segment of intestine; without tapering***

4412X2 – E2 ***Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis of proximal segment of intestine; with tapering***

The facilitation committee obtained a more in depth interpretation of the work being performed for these two codes by the pediatric surgeon, especially in the post service period. The facilitation committee was satisfied that the surgeon would be performing the post service work, in that the surgeon would see the patient everyday. The length of stay for these patients is high, 21 days for EE1 and 26 days for EE2. The committee felt that even if all of the critical care post operative days were reduced to the level of 99231, the post operative time and effort justifies the specialty's **recommended RVWs for EE1 and EE2 of 35.5 and 41.1.** The facilitation committee was also comfortable with the IWPUT for both of these codes.

4412X3 – E3 ***Enterectomy, resection of small intestine for congenital atresia; single resection and anastomosis of proximal segment of intestine; each additional resection and anatomosis (Use 4412X3 in conjunction with 4412X1, 4412X2)***

The facilitation committee felt that the time associated with this code was correct after reviewing three other codes;

22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)*

35600 *Harvest of upper extremity artery, one segment, for coronary artery bypass procedure*

38746 *Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)*

Each of these codes have 40 minutes of physician intra-service time and have RVWs of 6.44, 4.95, and 4.39 respectively. Therefore, **the facilitation committee recommends an RVW of 4.45 for E2**. This is the same RVW as the reference code, and lower than the specialty society's recommended RVW of 5.00.

Facilitation –urology

Rich (Chair), Gee, Koopman, Hannenberg, Levy, Taubman, Maybry, and Regan

5385X *Transurethral destruction of prostate tissue; by water-induced thermotherapy*
The faciliation committee met during lunch and reviewed several different codes across specialties and thought found that code 54670, *Suture or repair of testicular injury* was similar in physician work and time, with 30 minutes pre, 60 minutes intra-service, and 43 minutes post. 54670 was then the anchor code, and has a work RVU of 6.41 RVUs. The pre, post, and intra-service time provided the committee an excellent cross walk to 5385X. In addition to the relativity to 54670 in time, the code's relativity of the IWPUT is similar to this code at .052. The facilitation committee believed that since the work of 54670 was less than code 5385X, the group recommends a value of **6.50 RVUs for code 5385X.**

Reference code, 53850 has 60 minutes pre, 50 intra, and 45 minutes in post time.

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Hallux Valgus Repair (Tab 27)
Facilitation Committee Report

Facilitation Committee #2 (Doctors Schnur, Blankenship, Bradley, Pfeifer, Gee, Regan, Schmidt, and Zwolak) met on Friday, April 27 to discuss code 28299 *Correction, hallux valgus (bunion), with or without sesamoidectomy, by ~~other methods (eg~~, double osteotomy~~)~~.* The RUC reviewed this code in the five-year review and recommended an increase from 8.88 to 9.18. The RUC did not agree to the specialties survey data at the time of the five-year review as there was concern that the CPT descriptor should be changed to be consistent with the vignette, which describe a double osteotomy. The RUC recommended that this issue be referred to CPT.

The CPT Editorial Panel reviewed this code and made revisions as suggested by the RUC. The specialty societies are now presenting their original work relative value and survey data.

The facilitation committee reviewed this service and determine that the work relative value for 28299 should reflect the work of 28296 *Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)* (work RVU = 9.18) plus an increment for the second osteotomy. The facilitation committee calculated the work of the second osteotomy as follows:

28310	*Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)*		5.43
	Less pre- and post-time:		
	99238 *Discharge Day Management*	1.28	
	99212 *Level 2 E/M Office Visit* (3 x .45)	1.35	
			2.63
	Intra-Service Work		2.80
	½ of Intra-Service Work (Incision already made)		1.40
	28299 (9.18) + 1.40 = 10.58		

The Facilitation committee recommends 10.58 for CPT code 28299.

Facilitation Committee Report- Hand/Finger/Wrist/Forearm Musculoskeletal/Vascular/Nerve Procedures – Tab 25 code 2502X1 – JJ12
April 27, 2001

Doctors Sawchuk (Chair), Gage, Maybry, Levy, Felger, and Hayes met after the RUC meeting to discuss code 2502X1 – JJ12

The facilitation committee recommends **16.54 RVUs** for 2502X, JJ12 . This is less than the original RVW of 18.48 recommended by the specialty society. The committee reviewed codes 25020 *Decompression fasciotomy, forearm and /or wrist, flexor or extensor compartment; without debridement of nonviable muscle and/or nerve* - RVW of 5.92 and 25023 *Decompression fasciotomy, forearm and/or wrist, flexor or extensor compartment with debridement of nonviable muscle and/or nerve* -RVW of 12.96. This resulted in a relative difference of 7.04 RVWs for the debridement of nonviable muscle and /or nerve. Applying this differential to JJ11, approved by the RUC for 9.50 RVW, the committee obtained a total RVW of **16.54 RVWs.**

Neurology Facilitation Committee Report – April 29, 2001 7:00am

WW1

The facilitation committee obtained a better understanding of the physician work of this code. They felt that this code indeed has physician work. The committee compared this code to 99214 and a 99203 in time and intensity. The test is one where it must be performed on the patient and quality medical decision needs to be made, and therefore the physician needs to perform this test. **The committee decided that a the 25th percentile of 1.10 RVWs,** correctly valued this code.

WW2

Based on a further review of the physician time and work, the committee believed that this code should be valued below the specialty's recommendation of 9.50 RVWs to **8.0 RVWs.** The committee believed the intra-service time of 180 minutes was justified, and the specialty society made the correct adjustment to the survey time of 240.

The practice expense for WW2 was discussed and the clinical labor staff mix was changed to RN/LPN/MA, and other changes may be made with the assistance of HCFA.

WW3

Based on the fact that the intra-service work was similar to the reference code 95961. The committee believed the intra-service time of 75 minutes was justified, and the specialty society made the correct adjustments to the survey times to 15 pre service time, 75 intraservice time, and 30 minutes post service time. The committee believed that WW3 should then be valued at **4.0 RVW,** which is below the specialty society's survey median and recommended value of 5.0 RVW.

WW4

The committee recommended **3.5 RVWs** which is the specialty's survey median, but below the specialty's recommended value of 4.5 RVWs. The specialty's survey results showed an intra-service time of 60 minutes, however the committee believed that it did not accurately reflect the total intra-service work. The committee thus believed that the intra-service time should be changed to 75 minutes. There is no pre, or post service time associated with this code.

Facilitation Committee Report – Urology Codes: April 27, 2001
Tab 21 – 5416X1 – L1
Tab 22 – 544X5 – Y6
Tab 23 – 6458X – N2

Doctors Sawchuk (Chair), Gage, Maybry, Levy, Felger, and Hayes met after the RUC meeting and discussed the following codes.

Tab 21 – 5416X1 – L1 ***Lysis or excision of penile post-circumcision adhesions***
The facilitation committee recommends a value of 3.00 for L1. This is less then the RVW of 3.27 originally submitted by the specialty society. There was some discussion regarding rank order anomaly of L1 versus L2 *Repair incomplete circumcision* at the original RVW of 3.27. There was also some discussion regarding adverse selection of L1 over L2 at differential RVWs. Therefore L1 was made equal to L2.

Tab 22 – 544X5 – Y6 ***Repair of component(s) of a multi-component, inflatable penile prosthesis***
The facilitation committee recommends a value of 12.75 for Y6. This is lower than the original RVW of 13.30 recommended by the specialty society. The facilitation committee recognized that this service had to be appropriately ranked within the other services already approved by the RUC. Y5 *Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis* was approved by the RUC at 12.10 RVWs. The services are similar except for 15 minutes additional intra-service time for Y6. After reviewing a number of different building block methodologies the committee felt that 12.75 RVWs appropriately reflected the work associated with this service.

Tab 23 – 6458X – N2 ***Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)***
The standard for N2 the facilitation committee recommends an RVW of 13.50. Which is the same value as is originally submitted by the specialty society. Upon discussion the facilitation committee determined that the work involved placement of electrodes through a scarred tract and re-performance of test stimulation to verify correct placement. Therefore, this service essentially involves re-performance of N1 *Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacralnerve)* together with the placement of new, permanent electrodes, and not the reutilization of existing electrodes or existing tracts.

The committee reviewed some zero day global services: 37205 (*Transcatheter occlusion or embolization*) with an RVW of 8.28, but no survey time data in the database, 32606 (*Thoracoscopy, diagnostic with biopsy*) with an RVW of 8.40 and an intra-service time of 90 minutes, and 52345 (*Cystourethroscopy with uretheroscopy; with treatment of uretheropelvic stricture)* surveyed in 2000 with an intra-service time of 90 minutes. The committee felt that the work involved with these services was similar to the work of N2 (median = 120 minutes intra-service). Accounting for the nominal pre-service (1.34) and post-service (4.09) associated with N2 the committee felt that the original survey median of 13.50 appropriately quantifies the RVW.

N1/N2 Practice Expense
For N1 the committee reviewed the staff time and found it appropriate. For supplies and equipment in-office an exam table was added to medical equipment. Otherwise the committee found supplies and equipment for N1 to be acceptable.

For N2 the committee determined that the pre-service involved five minutes for complete pre-service diagnostic and referral forms and 20 minutes for education/obtain consent for a total pre-service time of 25 minutes. For service period there were no inputs. Post-service, a total number of office visits of 1-

99214 (53 minutes) with 15 minutes for conducting phone calls/call in prescriptions for a total post-service time of 15 minutes. For supplies and equipment “out of office”, they are the same as N1.

Penile Prosthesis
Family Rank Order by RVW

Family Rank Order (1-10)	CPT Codes	Descriptor	Survey Median RVW	Survey Median IWPUT	Recommended RVW	Current RVW	IWPUT of Rec. RVW
1	544X1	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis.	8.20	0.074	8.20		0.074
2	54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	Not surveyed established code*			8.99	
3	54401	Insertion of penile prosthesis; inflatable (self-contained)	Not surveyed established code*			10.28	
4	544X2	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session.	10.87	0.063	10.87		0.063
5	544X4	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis.	12.10	0.074	12.10		0.074
6	544X5	Repair of component(s) of a multi-component, inflatable penile prosthesis	13.30	0.069	13.30		0.069
7	54405	Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir	Not surveyed established code*			13.43	
8	544X6	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	15.50	0.067	15.50		0.067
9	544X3	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue.	14.19	0.037	19.25		0.078
10	544X7	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session including irrigation and debridement of infected tissue.	16.00	0.027	26.07		0.08

* 54400, 54401 and 54405 represent only editorial changes by CPT. These codes are included on the Table as references for comparison of RVW of new codes and established codes.

Radiotherapy (Tab H)
Radiation Treatment Delivery (Tab I)
Facilitation Committee #2

Facilitation Committee #2 (Doctors Schnur, Blankenship, Bradley, Pfeifer, Gee, Regan, Schmidt, and Zwolak) met on Friday, April 27 to discuss code Radiotherapy and Radiation Treatment Delivery.

773XX (V1) *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications*

The specialty society agreed that a more appropriate recommendation would be the survey median of 8.00. The facilitation committee agreed that the survey median was appropriate. To validate the survey median, the facilitation committee considered the following additional rationale:

Building Block of Current Codes:

77295	*Set radiation therapy field*	4.57
77331	*Special radiation dosimetry (0.87 x 3)*	2.61
76370	*CAT scan for therapy guide*	0.85
76375	3d/holograph reconstr add-on	0.16
	Total	8.19

The facilitation committee recommends that the CPT Editorial Panel consider adding a note to CPT to specifically exclude the reporting of the above codes in conjunction with 773XX.

Intensity Calculation:

Median Survey Pre-Time	30 minutes x .0224	0.67

Intra-Service Time:

10-25 minutes:
- immobilize patient in treatment position for tumor volume localization CT

5-10 minutes:
- correlate planning CT scan used for tumor localization with other imaging studies, including MRI, PET, contrast enhanced plain film studies, and ultrasound imaging studies

10-15 minutes:
- enumerate critical normal tissues within and adjacent to tumor volume
- define partial dose/volume tolerances for these normal tissues

25-25 minutes:
- identify and segment tumor area on each CT slice within tumor volume
- identify and segment each critical normal tissue within each CT slice within and adjacent to tumor volume

5-10 minutes:
- explicitly develop normal tissue and tumor dose constraints for inverse planning algorithm
- for Peacock planning determine 1 or 2 cm index slice thickness
- for multi-leaf collimator IMRT work with physicist to suggest initial gantry and table angles for field families

20-30 minutes:
- evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints

5-10 minutes:
- work with physicist to modify tumor and normal tissue dose constraints if necessary to re-run plan
- continue to iterate plan until dose constraints are acceptable

5-8 minutes:
- specifically compare dose volume histograms for tumor and critical normal tissues

10-15 minutes:
- review phantom/film, TLD, or diode dosimetry performed by physicist to confirm correct plan parameters compared with graphical plan

Total Physician Intra-Time as Reviewed in Detail (95-158 minutes)

75th Percentile of the Survey = 131 minutes

	IWPUT 0.050 x 131 minutes =	6.55
Post-Service Time	35 minutes x .0224 =	0.78

Pre (0.67) + Intra (6.55) + Post (0.78) = 8.00

The Facilitation Committee recommends, based on the survey median and the other rationale above, that the work relative value for 773XX be 8.00.

Practice Expense

The facilitation committee received the attached revised practice expense inputs from the specialty and recommends that they be approved. The committee reviewed each element of clinical staff time in comparison to the activities performed by the physician.

The specialty recommends direct practice expense inputs for services performed in the office setting only.

Radiation Treatment Delivery (Tab I)

The specialty also provided revised practice expense inputs (see attached) for this service when provided in an office-setting. The facilitation committee reviewed these revisions and determined that the inputs appear reasonable.

Report of Facilitation Committee #6
Luncheon meeting, Saturday, April 28, 2001

Doctors Plummer (Chair), Gage, Gramm, Schnur, and Schmidt met at noon on Saturday, April 28, 2001 to review gait and motion studies; ablation of hepatic tumors; and gynecological oncology procedures.

Gait and Motion Studies (Tab 29)

The facilitation committee extensively discussed **code XX5 and determined that this service should be carrier priced** until relative value recommendations are presented based on a survey utilizing an appropriate vignette. The vignette used in the current survey included work that would be captured in a separately reportable evaluation and management service. It was suggested that the specialty also determine the typical number of tests to be interpreted and to work with the American Physical Therapy Association to ensure that the surveys of XX1-XX4 are coordinated with XX5.

Ablation of Liver Tumors (Tab E)

The facilitation committee agreed that the work of 4737X5 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* should be evaluated as follows:

Pre-Service	30 minutes x .0224	0.66
Intra-Service	180 minutes x .071*	12.78
Same day post	30 minutes x .0224	0.66
½ discharge day management		0.64
Office visit (99212)		0.45
Total work RVU		**15.19**

The committee agreed that this service was at least as intense as cyrosurgical ablation of the prostate (IWPUT = 0.71) and that the total work of code 55873 (February 2001 RUC recommendation = 19.19) is comparable to (or less than) the total work of the ablation of the liver tumor 4737X5, when the radiologic guidance code (F6, F7, or F8) is added to this code.

The facilitation committee recommends 15.19 for code 4737X5 (F5)

The facilitation committee also reviewed the radiologic guidance codes F6, F7, and F8 and determine that the relative values as presented by the specialty societies (SCVIR, ACR, and ACS) are appropriate. The committee agreed that this radiologic guidance may be performed by a second physician and that the intensity if less than an E/M intensity of 0.31. The committee compared an intensity of 0.026 per minute with the time for each of these services and **determined that the specialty recommendations of 4.00 (F6), 4.25 (F7), and 4.00 (F8) are appropriate.**

The practice expense for F5 has been modified to compare to the standard packages developed by the PEAC and approved by the RUC. There are no direct practice expense inputs for F6-F8.

Gynecological Oncology Procedures (Tab F)

The facilitation committee reviewed the work RVUs for codes M1 and M2 and agreed that the RUC misunderstood how these services are currently reported.

M1 is currently reported as follows:

58952	Resect ovarian malignancy	25.01
58150-51	Total hysterectomy (15.24*.50)	7.62
Total current value when performing this service		32.63

The committee accepts a specialty recommendation to reduce the pre-service time for this code to 90 minutes.

After reviewing this information, the committee agreed that the survey median of 32.00 for code M1 is appropriate.

M2 is currently reported as follows:

58952	Resect ovarian malignancy	25.01
58150-51	Total hysterectomy (15.24*.50)	7.62
38770-51	Remove pelvis lymph nodes (13.23*.50)	6.62
Total current value when performing this service		39.25

The committee accepts a specialty recommendation to reduce the pre-service time for this code to 90 minutes.

After reviewing this information, the committee agreed that the survey median of 35.00 for code M2 is appropriate.

The RUC had approved the standard practice expense inputs for these codes.

ASA Facilitation Committee
TAB 14

The facilitation committee met to review five of the codes contained in tab 14. All of these codes underwent a paper ballot and failed to receive RUC approval. The committee reviewed the ballot results and concluded that for three of the codes(EE3, EE8, and EE9) the RUC had very strong support for reducing the recommended base units by one base unit. The committee and the ASA agreed that such a reduction would reflect the RUC members suggested base unit recommendations and maintain proper rank order within the family.

The committee discussed EE4 and EE5 separately. The patient population for both of these codes is sick wiath comorbidities that complicates the anestehesia work. Since EE4 is currently billed as code 01920 at 7 base units, the committee felt that a straight crosswalk would be appropriate and recommended a base unit of 7. The committee and ASA agreed that this value would maintain proper rank order within the family.

EE5 was discussed in relation to EE4 and the additional work of providing anesthesia when considering the physiologial consequences of occluding the aorta or cardiac chamber and placing a multi- piece stent. The committee felt that a one base unit increment above EE4 reflected the incremental work between these two codes.

SUMMARY ANESTHESIA PROCEDURES FOR RADIOLOGY

Code		ASA recommended Value	Facilitation Committee Recommended Value	Descriptor
0190x5	EE1	6.0		Anesthesia for myelography, discography, vertebroplasty
01916	EE2	5.0		Anesthesia for diagnostic arteriography/venography
0193x1	EE3	6 .0	**5**	Anes for other interventional radiologic procedures, NOS
0193x2	EE4	8.0	**7**	Anes for ther inter rad proc carotid or coronary arteries
0193x3	EE5	9.0	**8**	Anes for ther inter rad proc, intracran, intracard, aortic
0194x1	EE6	5.0		Anes for ther inter rad proc, venous/lymphatic
0194x2	EE7	7.0		Anes for ther inter rad proc, TIPS
0194x3	EE8	7.0	**6**	Anes for ther inter rad proc, intrathoracic or jugular
0194x4	EE9	8.0	**7**	Anes for ther inter rad proc, intracranial

Radiation Therapy Pre-Facilitation Meeting
Committee #2, Thursday, April 26, 2001

Doctors Schnur (Chair), Gee, Schmidt, Blankenship, Regan, Zwolak, Pfeifer, and Bradley formed a Pre-Facilitation Committee after the RUC meeting, to discuss the work and practice expense of Radiotherapy and Radiation Treatment Therapy, Tabs H & I in the RUC agenda.

The pre-facilitation committee heard the presentation by the American Society for Therapeutic Radiation Oncology, on code **773XX,** ***Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications*****.** The committee had a number of concerns about the society's recommendation of 9.00 RVUs. One concern was that their recommendation was 1 unit above the survey median of 8.00 RVUs. The society justified difference from the median RVU based on their belief that the survey responses represented the simplest use of IMRT and it will often be more time and labor intensive than that the vignette would suggest. The work of this new code is similar to the work of the reference code 77295 plus two others, 76375 and 76370. The society, however, felt that 773XX is more intensive than the three codes combined. After a lengthy discussion, there was a majority opinion, that the survey median of 8.00 RVUs, more appropriately valued this new code.

The pre-facilitation committee noted that the society's practice expense recommendation included significant clinical labor time. The society explained that in order to pinpoint and test the exact location(s) where the high dose of radiation would be administered, extensive allied health time and effort was required. The society explained that all of the practice expense inputs were compiled through the use of a 12 member consensus panel. The pre-facilitation committee had no reason to question the practice expense inputs as presented.

The pre-facilitation committee discussed the Radiation Treatment Therapy code, **774XX,** ***Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams (binary, dynamic, MLC, etc.), per treatment session*****,** which has no physician work, but again has significant allied health time and other practice expense. The society again utilized a 12 member consensus panel to recommend the practice expense inputs for this code. The pre-facilitation committee had no reason to question the practice expense inputs as presented.

Urinary Sphincter
Family Rank Order by RVW

Family Rank Order (1-5)	CPT Codes	Descriptor	Survey Median RVW	Survey Median IWPUT	Recommended RVW	Current RVW	IWPUT of Rec. RVW
1	534X1	Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff	13.17	0.090	10.23		0.057
2	53449	~~Surgical correction of hydraulic abnormality of inflatable sphincter device.~~ Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir and cuff**	Not surveyed editorial change**			9.70	
3	53445	~~Operation for correction of urinary incontinence with placement~~ Insertion of inflatable urethral or bladder neck sphincter, including placement of pump ~~and/or~~ reservoir and cuff.**	Not surveyed editorial change**			14.06	
4	5344X6	Insertion of tandem cuff	13.40	0.069	13.40		0.069
5	53447	Removal and replacement of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff at the same operative setting	14.08	0.064	14.08		0.064
6	534X2	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue.	15.00	0.022*	24.86		0.079*

*Note: The 75th percentile IWPUT (0.058) is the calculated value in the Summary of Recommendations form under tab 19 of your RUC book.

**Note: 53445 and 53449 represent editorial changes by CPT in order to keep the nomenclature of these codes consistent with new codes. There is no change in work value therefore, the codes were not surveyed. These codes are included on the Table as references for comparison of RVW of new codes and current established codes.

Practice Expense Subcommittee Report
Approved at the April 2001 RUC Meeting

The Practice Expense Subcommittee met to develop a recommendation for physician time for dialysis codes. The following subcommittee members participated: Doctors Gage (Chair), Lichtenfeld, Mayer, McCaffree, Plummer, and Walter Smoski, PhD. Doctor Florin also participated in the meeting. Doctor Emil Paganini represented the Renal Physicians Association.

As a result of the HCFA review of the RUC physician time submission, HCFA questioned the RUC time submitted for codes 90921 through 90925. It was discovered that the original summary of recommendation form was altered to not include the pre and post-service time for the code, and therefore the time submitted to HCFA was incorrect. As a result, the RUC met on short notice to clarify the RUC recommendation of physician time for these codes. After discussing the RUC recommendation on work relative values from 1994, the RUC agreed to use the same building-block methodology for developing physician time as was used for developing the work relative value. For code 90921, the RUC utilized the following building block methodology to develop the work RVU:

Calculation of RUC RVW Recommendation for code 90921

FOR HEMODIALYSIS

Total number of dialysis per month		13	(Standard – patient receives dialysis 3 times per week)
Total number of visits per month		6.9	(Mendenhall = 6.8/1991 RPA Survey = 6.9)
Visits in office	1.2		(1991 RPA Survey)
Visits in dialysis unit	5.7		(1991 RPA Survey)
Interventions in dialysis		3.3	(1991 RPA Survey)

Translation to Equivalent Work Values

Face to Face:		
99215 (1.51) X 1.2	1.812	(1991 RPA Survey and 1994 RUC Survey)
99213 (0.55) X 3.3	1.815	(3.3 interventions per month – 1991 RPA Survey)
99212 (0.38) X 2.4	0.912	(remaining dialysis visits per month)
Total Visits 6.9		

Care Plan Oversight: 99375 (1.06) X 1 1.060

Hemodialysis Relative Work Value 5.599

FOR PERITONEAL DIALYSIS:

47% of hemodialysis (5.599 X .47) 2.632 (Ratio used by RUC and CMD panel in previous calculations)

Blend of Hemodialysis (82% of Patients) and Peritoneal Dialysis (18% of Patients)
(0.82 X 5.599) + (0.18 X 2.632) = **5.06**

The RUC agreed that the physician time should mirror this building block methodology and used the following calculation that utilized the full RUC times for the 1.2 office visits and the care plan oversight, but agreed that only the face to face time should be used for the remaining E/M visits. The face to face time was used rather than the full time because the committee and the Renal Physicians Association representative agreed that including all of the pre and post service time for these visits would lead to double counting of pre and post-service time. Using the same building block methodology, a total of 182 minutes for code 90921 calculated as follows.

99215 1.2 X 59=71
99213 3.3 X 15=49.5
99212 2.4 X 10=24
99375 =57 minutes
total hemodialysis time = 201.5
total peritoneal dialysis = .47X201.5=94.7

(.82 X201.5) + (0.18X94.7) = **182 minutes total time**

Since the work value for 90925 was developed by taking 1/30 of the value of 90921, the RUC aged to use the same methodology for calculating physician time and recommends 6 minutes for 90925.

The RUC recognized that recommending this time for code 90921 creates a rank order anomaly within the time currently used for this family of codes, but at this time the RUC recommends that HCFA review the times that it is currently using for this family to remove any possible rank orders.

- **The RUC recommends that HCFA not use the RUC times previously submitted in March 2001 for ERSD services (codes 90918 through 90925).**

- **The RUC recommends 182 minutes of physician time for code 90921 and 6 minutes for code 90925.**

- **The RUC will continue to review the physician time of the pediatric ERSD services (90918 – 90920, 90922 – 90924)**

RUC Health Care Professionals Advisory Committee Review Board
April 25, 2001

The RUC HCPAC Review Board met on Wednesday, April 25, 2001. The Review Board re-elected the Co-Chair and Alternate Co-Chair; reviewed issues related to Gait and Motion Studies; Active Wound Care Management; Health Behavior and Assessment. The committee also reviewed the PEAC recommendations for codes submitted by non-MD/DO specialties. The Review Board welcomed a new member, Karen Smith, MS, RD, LD, FADA of the American Dietetic Association.

Election of Co-Chair and Alternate Co-Chair

The Review Board has elected Don E.Williamson, OD as the Co-Chair of the HCPAC and to serve as the representative to the RUC. Eileen Sullivan-Marx, PhD, RN was elected to the Aternate Co-Chair position.

Gait and Motion Studies

The Review Board considered a letter and presentation from the American Physical Therapy Association (APTA) that explained that the gait and motion studies (XX1-XX4 only) were not surveyed for this meeting due to a mis-understanding regarding the vignettes. APTA noted that the RUC review of the physician interpretation code (XX5) would be helpful in clarifying that the interpretation work should be in this code (XX5) and XX1-XX4 should describe the performance of the tests.

The Review Board recommends that these codes (XX1-XX4) be carrier priced for 2002 and survey data be presented to the HCPAC in September 2001.

Active Wound Management

The Review Board had approved work relative value units for the active wound management codes at the February 2001 meeting. The APTA presented practice expense data for codes 97601 and 97602 at this meeting. The Review Board made adjustments to the clinical staff and held extensive discussions regarding the supplies and equipment. Modified lists of direct practice expense inputs will be forwarded to HCFA.

Health Behavior and Assessment

The HCPAC Review Board reviewed the Health Behavior and Assessment codes and approved the work relative value recommendations for all services (with the exception of the group code – 909X4) at the February 2001 meeting. The American Psychological Association and the National Association of Social Workers presented a recommendation for the group code. The Review Board agreed that the code should be between 99141 Preventive Medicine group, medicine counseling, 30 minutes (work rvu = 0.15; .08 per

15 minutes) and 90853 Group psychotherapy (work rvu = 0.59; .15 per 15 minutes) and recommends the following.

909X4 (G4) Health and behavior intervention, each 15 minutes, group (2 or more patients) .10 Work RVU

The Review Board noted that the typical group size of 6-8 patients is consistent between these codes.

The Review Board also approved a supply package (valued at 37¢) for these codes. There are no inputs for clinical staff or equipment.

PEAC Recommendations

The PEAC submitted practice expense inputs for 48 codes to the Review Board. The AAOS had requested that the Review Board refer the practice expense inputs for 11043 & 11044 (out-of-office setting only) back to the PEAC to obtain input from orthopaedic surgery, plastic surgery, and general surgery. With the exceptionof these two codes, the Review Board approved the PEAC recommendations.