AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE MEETING
The Pointe Hilton Resort at Squaw Peak
Phoenix, Arizona
February 3-6, 1994

**MINUTES**

## I. Call to Order

Grant V. Rodkey, MD, Chair
Robert Berenson, MD
Robert Florin, MD*
John O. Gage, MD
Timothy Gardner, MD
Arthur Garson, Jr., MD*
Tracy R. Gordy, MD
Michael Graham, MD
Kay K. Hanley, MD
W. Benson Harer, Jr., MD
James E. Hayes, MD
Charles Koopman, Jr., MD
Steven A. Kamenetzky, MD*
George F. Kwass, MD
Michael D. Maves, MD
David L. McCaffree, MD
Kenneth A. McKusick, MD
Clay Molsted, MD*
James M. Moorefield, MD
L. Charles Novak, MD
Eugene S. Ogrod II, MD
Robert Peters, DO*
Byron Pevehouse, MD
Peter Sawchuck, MD*
Chester W. Schmidt, Jr., MD
Paul Schnur, MD*
Howard Shapiro, MD
Gregory A. Slachta, MD
Ray E. Stowers, DO
Richard Tuck, MD
John Tudor, Jr., MD
Richard Whitten, MD*
William L. Winters, MD
(* indicates alternate member)

Doctor Rodkey opened the meeting at 8:18 a.m. He introduced Kay Jewell, MD, of HCFA, and Richard Whitten, MD, alternate AMA representative.

## II. Approval of November 19-21 Minutes

Two amendments were made:

•Page 14, item 19, Cornea Procedures, should be corrected to show that code 65771 (radial keratotomy) was referred to the Research Subcommittee with the cosmetic procedures because it is not covered by insurance.

•Page two, the phrase "within the family" should be added to the second full paragraph to give greater emphasis to Bernie Patashnik's discussion of budget neutrality within a family of codes.

The minutes were approved as amended.

## III. Calendar of Meeting Dates

Doctor Rodkey reported that Doctors Kwass and Whitten will be speakers at the AMA conference on May 5-6, 1994, on use of the RBRVS in the private sector. Staff announced that conference registration fees will be waived for members of the RUC, but the privilege is not transferable.

## IV. CPT Update

Doctor Gordy reported that the CPT Editorial Panel will have two meetings -- one in February and another in March -- before the RUC's next meeting in May. The Panel plans to consider vignettes for new and revised CPT codes as part of the coding proposals. Thus, both CPT and the RUC will be "on the same playing field."

CPT plans to maintain continuity in the CPT/RUC vignettes by advising the RUC if the vignettes are changed during the CPT process. There was extensive discussion about coordinating the development of vignettes, especially in view of the urgency of forwarding the results of the May RUC meeting to HCFA for the 1995 Medicare RVS. It was suggested that the Research Subcommittee review the CPT vignettes before the May RUC meeting. Some members indicated that the CPT development of vignettes would infringe on the RUC's responsibility to develop vignettes. **There were two separate but similar motions regarding creation of a three- or four-member ad hoc committee to review the vignettes from the February and March CPT meetings and determine their suitability for use in the specialty societies' surveys. Both motions were defeated.** Some arguments against the motions were that (1) the ad hoc committee would establish an additional level of review, (2) validating CPT vignettes would exceed the RUC's charter of reviewing CPT actions, and (3) it would increase the cost of the specialty societies' involvement in the RUC if they had to send a RUC member or alternate to another committee meeting.

## V. Research Subcommittee Report

Doctor Kwass reported on a number of items that had been discussed at the January 8, 1994, Research Subcommittee meeting. The subcommittee had suggested that the staff develop a list of types of arguments that the Carrier Medical Director review panels typically use when they review RUC recommendations. The staff circulated the resulting list as a hand-out.

The subcommittee had also discussed the CPT Editorial Panel's plan to develop vignettes for new and revised codes. The subcommittee determined that if there is a difference between the CPT vignette and the specialty society survey vignette, the specialty society would need to explain the discrepancy to the RUC. The subcommittee had concerns about the suitability of using CPT vignettes in RUC surveys. For example, the vignettes should narrowly define a typical service in a way that minimizes the likelihood of "leading" physician respondents to a particular conclusion or of causing confusion about the meaning of codes. Because of its concerns, the subcommittee recommended that the CPT vignettes be forwarded to the Specialty Society RVS Committees as soon as they become available.

Following up on a memo discussed at the November meeting regarding addition of codes to specialty reference lists for use in surveys for revised codes, the Research Subcommittee amended the language on specialty reference sets in the Instructions to Specialty Societies.

**The RUC adopted a motion to accept the Research Subcommittee report.**

Two other discussions at the Research Subcommittee had lead to development of supplementary subcommittee reports. A workgroup comprised of Doctors Maves, McCaffree, and Berenson developed a report on periodic review of services which was presented to the RUC for information. This report addressed selection criteria for periodic review and indicated that all codes coming before the RUC will be monitored and reviewed on a three-year basis beginning with codes considered in calendar year 1992. New technology codes would be reviewed on an annual basis. Factors to be monitored would be frequency, expenditures, site of service, length of stay, number and type of providers, and scientific information. The report also addressed review criteria, recommending that changes of 5% annually and 10% over three years be initially considered for review. **The RUC adopted a motion to accept the report, which is attached to these minutes.**

Doctor Kwass also presented a report of the Research Subcommittee's work group on relative values for "restricted" procedures, such as cosmetic or medically unnecessary procedures that patients, rather than insurance carriers, typically pay for. Although the initial work group report included a series of recommendations, the subcommittee decided not to offer them to the RUC to vote on. Some RUC members expressed disappointment with the report. They said that they preferred not to have work values for such codes because publishing work values could inhibit the physician's ability to obtain the market price for a service that physicians usually provide to meet a consumer demand. On the other hand, it was noted that HCFA was interested in having relative values for every code in CPT and that, if the RUC does not recommend values for cosmetic or medically unnecessary services, HCFA may develop its own values. **After both sides had been heard, the RUC adopted a motion to accept the work group report.**

## VI. Cross-Specialty Reference List Subcommittee Report

Doctor Gage reported on the February 3 meeting of the Cross-Specialty Reference List Subcommittee. He said that staff had compiled a list of potential reference services using the criteria adopted at the November RUC meeting. The list will be distributed to the specialty societies for comments. The subcommittee will review the specialty comments before the next RUC meeting. The subcommittee's report was received for information.

## VII. HCFA Update

Kay Jewell, MD, announced that the Spring proposed rule will include an update on Geographic Practice Cost Indexes (GPCIs); multiple procedure policy; proposed values for non-covered and carrier-priced services; and case management. In response to questions, she said that HCFA believes that the work values from the Hsiao study were sound, but it recognizes that there have been changes in the RBRVS since the Hsiao study. She noted that Mr. Patashnik had already addressed the committee about the changes in work values that resulted from budget neutrality adjustments, adding that the across-the-board reduction was "out of our hands."

Doctor Ogrod discussed the issue of using the RBRVS to reimburse physicians for capitated care, which he described as one of the "most significant problems facing medicine." **There was a motion to refer the question to the Research Subcommittee, but after it was mentioned that the AMA Board of Trustees is considering the issue and that it was beyond the RUC's charge, the motion failed.**

## VIII. Review of 1994 Interim Values

Prior to the meeting, specialty societies were invited to provide the RUC with comments on the interim values published in the December 2 Rule for discussion at the RUC meeting. Jerry Stone, MD, a Carrier Medical Director, participated in the portion of the RUC meeting addressing these comments to augment the explanations provided in the Rule. Doctor Stone described the process used by the CMDs to review the RUC recommendations and commented on the value of both the RUC and CMD review. He concluded his remarks by saying that the CMDs are "a fair bunch," most of them are board certified, many of them were practicing physicians, and they identify with and are sympathetic to practicing physicians.

The RUC discussed HCFA's reductions from the RUC-recommended values for several of the codes in the Rule, including code 44615 for intestinal stricturoplasty, code 48150 for the Whipple procedure, and code 38102 for splenectomy. Doctor Jewell suggested that it would be more productive for the concerned specialty Advisors to meet directly with HCFA staff than for the RUC to continue through all of the specialty comments that were received. RUC members expressed support for this suggestion, so Doctor Rodkey ended the discussion at the meeting. **A motion was made for the RUC to reaffirm its support for all of its recommendations for the 1994 RVS. Comments suggested that such a reaffirmation would be premature in the absence of a more complete discussion of the recommendations that were not adopted, and the motion failed.** [Staff note: In follow-up to this discussion, it is our understanding that selected RUC Advisors and two RUC members will be invited to participate directly in HCFA's summer refinement process for the 1994 interim values.]

## IX. Relative Value Recommendations

1. **Reconstructive And Cosmetic Surgery[Tab 6]**
   CPT Code Numbers: 30450, 30400-30420, 30430, 30435
   Presentation: Patricia Gomukwa, MD; Charles Koopman, MD

American Society of Plastic and Reconstructive Surgeons, Inc., American Academy of Otolaryngology - Head & Neck Surgery, Inc., and American Academy of Facial Plastic and Reconstructive Surgery

At its November meeting, the RUC adopted recommendations for a family of rhinoplasty codes, with the exception of code 30450, rhinoplasty, secondary; major revision (nasal tip work and osteotomies), which was referred to a facilitation committee chaired by Doctor Graham for further review. The RUC adopted the facilitation committee's recommendation to reduce the specialty's original recommendation of 20.00 to 18.75. Code 30450 is similar to code 30462 [Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies, 19.19 RVW].

2. **Dentoalveolar Structures[Tab 7]**
   CPT Code Numbers: 41822, 41823, 41828, 41830, 41872, 41874
   Presentation: Jeffrey Resnick, MD; Charles Koopman, MD

American Society of Maxillofacial Surgeons, American Society of Plastic and Reconstructive Surgeons, Inc., American Academy of Otolaryngology - Head and Neck Surgery, Inc.

This issue was originally discussed by the RUC at its November meeting. The RUC felt that the typical vignettes described in the original survey did not reflect the services and referred the issue back to the specialty societies. The revised recommendations considered at the February RUC meeting were substantially lower than those proposed earlier and are based on a consensus panel of six physicians that also have degrees in dental surgery. The consensus panel was able to compare these

services with reference services with existing relative values. The RUC thought the only appropriate way to value codes 41872 or 41874 was on a per quadrant basis and suggested that the specialty society submit a request for the revision to the CPT Editorial Panel. These services are most commonly performed by dentists and are typically covered by dental insurance rather than medical insurance. The American Dental Association provided the following dental code crosswalks:

| | |
|---|---|
| CPT 41822 = ADA 7470 | CPT 41830 = ADA 7999 by report |
| CPT 41823 = ADA 4260 | CPT 41872 = ADA 4210 |
| CPT 41828 = ADA 7970 | CPT 41874 = ADA 7320 without extraction |

3. **Pediatric Neurosurgery[Tab 9]**
CPT Code Numbers: 61559, 61564
Presentation: Robert Florin, MD, American Association of Neurological Surgeons

CPT codes 61559 and 61564 had a survey response level of 100%. The recommended median survey value of 28 pediatric neurosurgeons for CPT code 61559 is 32.00 RVW and for 61564 33.00 RVW. CPT code 61564 was previously surveyed with an incorrect CPT code descriptor. The descriptor did not include optic nerve decompression which represents a good portion of the work, and poses a significant amount of risk for this procedure.

The primary key reference service for 61559 is 61552 with an RVW of 19.48. 61559 requires multiple craniectomies but is more complex due to the need to decompress the entire skull, including orbits and anterior basal regions. The key reference services for 61564 are 61512, 61518, and 61700, which have RVWs ranging form 24.85-35.68. The techniques of the key reference services are similar to resection of a sphenoid ridge meningioma except for the age and size of the patient and the invasion of the orbit. Additional dissection, usually with the microscope, is required for exposure and decompression of the optic nerve.

4. **Modification of Ocular Implant[Tab 10]**
CPT Code Number: 65125
Presentation: Arthur Perry, MD, American Academy of Ophthalmology and American Association of Ophthalmologic Plastic and Reconstructive Surgery

Doctors Kamenetsky and Tudor consulted on this code and the RUC adopted their recommendation to reduce the specialty's original recommendation from 5.55 to 3.00 RVW. This reduction represents a 50% decrease in the work value when compared to the key reference service 65920 [Removal of implanted material, anterior segment eye, 8.10 RVW]. In addition, the RUC suggested that the specialty society work with the CPT Editorial Panel on clarification of the nomenclature of the code to ensure that this CPT code applies to a procedure that includes one or more peg placements.

5. **Orthopaedic Surgery[Tab 11]**
CPT Code Numbers: 26580, 28360, 64876
Presentation: Alan Morris, MD, American Academy of Orthopaedic Surgery

The RUC recommended ratings were based on a survey of 39 orthopaedic surgeons. A frequency weighted average was derived from two vignettes for both CPT codes 26580 and 28360. The recommended values are 17.71 RVW for CPT code 26580 and 12.79 RVW for CPT code 28360.

CPT codes 26580 and 28360 are procedures that are performed to treat anomalies that are very rare. General orthopaedic surgeons are not likely to have ever treated these patients. The specialty society Advisor noted that there is really no such thing as the typical patient, therefore 2 vignettes were developed. When the survey was disseminated respondents were asked to rate each vignette, as well as provide information on the frequency of each patient scenario.

CPT code 26580 - Repair cleft hand, is performed due to the absence of central rays and/or digits. The deformity is characterized by a deep v-shaped or funnel shaped defect in the hand. The correction of syndactyly is often required as a result of this defect. The RUC noted a discrepancy between the RVW for the reference service, CPT code 26561 - 10.76 RVW vs. the recommendation of 17.71 RVW for CPT code 26580. The specialty society Advisor felt that since the repair of a cleft hand is microscopic in nature and further complicated by the age of the patient, the recommended RVW of 17.71 is justified. In comparing the recommended value of 26580 to the key reference service 26561, the specialty society Advisor also noted that a significant portion of the post-operative work for 26580 is focused on the maintenance of the dressing, cast and close monitoring of wound healing. The post-operative period is made more difficult because the patients are young children, which increases the intensity of the follow-up care provided, which includes dressing changes. The number of post-operative visits required ranges between 5 and 5.5.

CPT code 28360 - Reconstruction, cleft foot, is performed due to a central ray defect and/or the absence of one or more medial rays. The specialty society Advisor noted that the dressing changes for 26580 are much more intense than for 28360. This difference in intensity of follow-up care is reflected in the number of post-operative visits required for 28360 which ranges from 4.5 to 6.5.

64876 - Suture of a nerve; requiring shortening of bone of extremity (list separately in addition to code for nerve suture). A recommendation will be made by the specialty society to the CPT Editorial Panel to have this code deleted.

6. **Microsurgery/Hand Surgery[Tab 14]**

CPT Code Numbers: 20802, 20805, 20808, 20816, 20822, 20824, 20827, 20838, 25915, 26550, 26555, 26585, 20955, 20960, 20969, 20970-20973

Presentation: Daniel Nagle, MD; Neil Jones, MD; Paul Petty, MD

American Society of Plastic and Reconstructive Surgeons, Inc., American Society of Reconstructive Microsurgery

Microsurgeons, plastic surgeons, and otolaryngologists developed joint recommendations for these services using three methodologies: survey median of physicians familiar with microsurgery, survey mean of the same group of physicians, and a building block approach using the component services in each surgery. The RUC considered these services to be some of the most difficult procedures in medicine, requiring similar amounts of intensity, skill, and time as the more difficult neurosurgery and transplant surgery procedures. The RUC agreed with the relationships established between the codes in each family of procedures, but referred the issue to a facilitation committee chaired by Doctor Graham to determine an appropriate value for the base code for each family. The facilitation committee was convinced that the initial relative values proposed by the specialty needed to be appropriately linked to similar neurosurgery and general surgery procedures with existing values in the RVS.

The RUC emphasized the difference between the methodologies used in developing the RUC recommendations and the Harvard study. The Harvard study included the opinions of only five orthopaedic surgeons, whereas the RUC survey included the insights of over 60 microsurgeons who are very familiar with these services, including several who had performed these services within the past year.

It should also be noted that several of the existing codes for incomplete replantation, hand surgery, and microvascular flaps need to be either clarified or deleted. The specialty societies involved will be proposing coding revisions to the CPT Editorial Panel in the near future and the RUC recommended that relative values for these services be deferred until after this process is complete.

<u>Replantation (Arm, Forearm, and Hand):</u>

Assuming that the proposed relationship between the three codes (20802, 20805, and 20808) in this family was correct, the facilitation committee evaluated the relationship of the proposed RVW for the base code 20802, replantation, arm, to other reference services. The committee decided that this service should be linked in intensity of other procedures, including the Whipple procedure and transplant surgery, with an intensity of 4.50 RVWs per hour of intra-service time. Assuming this relationship, the RUC recommended a value of 50.00 for replantation of the arm (20802); 70.46 for replantation of the forearm (20805); and 76.08 for replantation of the hand (20808).

<u>Replantation (Digit and Thumb):</u>

Judging the proposed relationship between the four codes (20816, 20822, 20824, and 20827) in this family to be correct, the facilitation committee evaluated the relationship of the proposed RVW for the base code 20816, replantation, digit to other reference services. The committee decided that these services should reflect the intensity of pediatric neurosurgery services that the RUC had recently evaluated. After reviewing the available survey data, the committee found that the intra- and post-service time, as well as the average length of hospital stay and number and level of

post-hospital visits, were very similar to pediatric neurosurgery service code 61564 for [Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); with optic nerve decompression], approved by the RUC earlier at 33.00. The RUC recommended, therefore, a value of 33.00 for code 20816; 30.03 for 20822; 35.68 for 20824; and 31.22 for 20827.

Replantation (Foot):

The committee was convinced that the work of replantation of the foot is equivalent to the work of replantation of the arm, therefore an RVW of 50.00 was recommended for code 20838.

Microvascular Flaps:

Judging the proposed relationship between the five codes (20955, 20969, 20970, 20972, and 20973) in this family to be correct, the facilitation committee evaluated the appropriateness of the proposed RVW for the base code 20955 [Bone graft with microvascular anastomosis; fibula]. The committee felt that the relative value determined by the building block approach was more appropriate than the higher survey median and mean. Based on this assumption, the RUC recommended a value of 38.00 for code 20955; 44.28 for 20969; 44.10 for 20971; 44.22 for 20972; and 47.29 for 20973.

Hand Surgery:

Doctor Maves is working with the specialty societies on the four hand surgery codes (25915, 26550, 26555, and 26585), which the facilitation committee was not able to complete at the February RUC meeting. A facilitation report will be presented at the May RUC meeting.

7. **In Vitro Fertilization[Tab 16]**
CPT Code Numbers: 58970, 58972, 58974, 58976
Presentation: Larry P. Griffin, MD; George Hill, MD
American College of Obstetricians and Gynecologists, American Fertility Society

A facilitation committee committee was formed to consider this issue, chaired by Doctor Moorefield, and the RUC adopted the facilitation committee's recommendations.

The recommended median survey values for CPT codes 58970 (3.70 RVW) and 58976 (4.00 RVW) were based on a survey that included 70 obstetricians/gynecologists and reproductive endocrinologists for code 58970 and 65 obstetricians/gynecologists and reproductive endocrinologists for code 58976, which is more than twice the number of responses required by the RUC.

Follicle puncture for oocyte retrieval, any method CPT code - 58970, is performed for the retrieval of eggs and assumes that the patient has undergone ovarian stimulation, with hormonal therapy to increase oocyte production. During the procedure multiple follicles on an ovary are stimulated using ultrasonic guidance or laparoscopy. The vagina is inspected for bleeding and after the inspection the patient is transferred to a recovery room to monitored for complications. It was noted that this procedure is performed both laparoscopically and open. Although the open procedure is more difficult, CPT code 58970 would used to report both.

CPT code 59872 can be performed two ways. During the Gamete intra-fallopian tube transfer (GIFT) procedure, a mixture of ova and sperm is placed into a catheter, and the ova/sperm mixture is then injected directly into one or both fallopian tube(s), via laparoscopy. This procedure is performed

immediately following oocyte retrieval. The Zygote intra-fallopian transfer (ZIFT) is performed the day after oocyte retrieval. The oocytes are combined with sperm and allowed to reach the pronuclear stage. At this time the sperm/zygote combination is placed into a catheter and injected into one or both fallopian tube(s), via laparoscopy.

The specialty society Advisor clarified for the RUC that the decision for a patient to undergo intra-fallopian vs. intra-uterine insemination is patient preference unless clinically indicated. The specialty society Advisor also confirmed for the RUC that since CPT codes 58970 and 58976 are usually performed laparoscopically, a separate code for laparoscopy would not be separately reported.

Recommendations for CPT codes 58972 [Culture and Fertilization of oocyte(s)] and 58974 [Embryo transfer, any method] were referred back to the specialty societies.

8. **Ambulatory Blood Pressure Monitoring[Tab 18]**
CPT Code Numbers: 93784, 93786, 93788, 93790
Presentation: Joe R. Wise, Jr., MD, FACC, American College of Cardiology

This issue was referred back to the specialty society.

9. **Esophageal Surgery[Tab 20]**
RUC Tracking/CPT Code Numbers: F8 - F23, 32820
Presentation: Peter Pairolero, MD, FACS, Society of Thoracic Surgeons/American Association for Thoracic Surgery, American College of Surgeons

The RUC recommendations for the esophageal surgery codes were based on the survey median of 45 general surgeons and thoracic surgeons. These services have been performed since the 1950s, however, they were previously reported as fragmented services. The coding revisions for CPT 1995 will bundle the procedures. In evaluating these codes, the RUC carefully considered the crosswalks from the 1994 codes to the new and revised codes for 1995. The relative value recommendations were estimated to be work neutral.

431XB [Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal), 27.50 RVW recommended] is the same work as CPT code 43119 [Total esophagectomy with gastropharyngogstomy, without thoracotomy], which has an RVW of 27.50. CPT code 43119 was revised to better reflect the service that the physician is performing. The RUC noted that 431XB is almost always performed with a pyloroplasty, even though the CPT descriptor for the code reads "with or without pyloroplasty".

The service described by 431XC [Total or near total esophagectomy, without thoracotomy; with colon interposition or small bowel reconstruction, including mobilization, preparation, and anastomosis(es), 33.00 RVW] is the same physician work as a combination of three CPT codes: 43119 [Total esophagectomy with gastropharyngostomy, without thoracotomy]; 44130 [Enteroenterostomy, anastomosis of intestine; (separate procedure)]; and 44140 [Colectomy, partial; with anastomosis, using the -51 modifier]. The total amount of physician work of these three services is reflected in the 33.00 RVW for 431XC.

431XE [Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty , 30.00 RVW] and 431XF [Total or near total esophagectomy, with thoracotomy; with colon interposition or small bowel reconstruction, including mobilization, preparation, and anastomosis(es), 34.00 RVW] both require the physician to perform a thoracotomy in addition to a laparotomy, which requires additional work. 431XE is the same physician work as a combination of CPT codes 32100 [Thoracotomy, major; with exploration and biopsy, 10.18 RVW] and 43119 [Total esophagectomy with gastropharyngostomy, without thoracotomy, 27.50 RVW]. 431XF requires the same physician work as the reference services: 43119 [Total esophagectomy with gastropharyngostomy, without thoracotomy, 27.50 RVW], 44130 [Enteroenterostomy, anastomosis of intestine; (separate procedure), 11.21 RVW]; and 44140 [Colectomy, partial; with anastomosis, 17.27 RVW]. Although the physician work for 431XC is similar to 431XF, 431XF includes a thoracotomy.

431XH [Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction, 30.00 RVW] describes a partial esophagectomy. The physician work for this service includes the placement of a prejejunal transplant into the neck with anastomosis and microvascular transfer. There were no codes in CPT to adequately describe this service, therefore this procedure was probably reported as an unlisted procedure code. The physician work involved in 431XH is similar to the combination of codes: 15755 [Free flap (microvascular transfer), 28.65 RVW]; 43100 [Excision of a local lesion, esophagus, with primary repair; cervical approach, 8.56 RVW]; and 44130 [Enteroenterostomy, anastomosis of intestine; (separate procedure), 11.21 RVW]. The RUC noted that this is a rare procedure that is performed on less than 250 Medicare patients per year. The RUC also noted that 431XH is usually performed with two surgeons, and the code would be reported with the -62 modifier.

431XI [Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis), 28.79 RVW] and 431XJ [Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small bowel reconstruction, including mobilization, preparation, and anastomosis(es), 32.00 RVW] describe a partial esophagectomy performed at the distal 2/3 portion, via thoracotomy and laparotomy. The physician work involved in 431XI is similar in nature to CPT code 43110 [Esophagectomy (at upper two-thirds level) and gastric anastomosis with vagotomy; with or without pyloroplasty, 28.79 RVW], therefore the recommended RVW is the same. 431XJ includes a bowel reconstruction, colon interposition and anastomosis. 431XJ is considered a combination of 43110 and 44140 [Colectomy, partial; with anastomosis, 17.27 RVW].

431XL [Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty, 28.00 RVW] is also similar to code 43110, but without the abdominal incision. Therefore, the RUC recommended a slightly lower RVW of 28.00. 431XM [Partial esophagectomy, thoracoabdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty, 28.00 RVW], although similar to CPT code 43120 [Esophagogastrectomy (lower third) and vagotomy, combined thoracicoabdominal, with or without pyloroplasty, 26.35 RVW], is considered more difficult than 43120 because the physician must perform a thoracoabdominal incision. 431XN [Partial esophagectomy, thoracoabdominal approach, with or without proximal gastrectomy; with colon interposition or small bowel reconstruction, including mobilization, preparation, and anastomosis(es), 32.00 RVW] is the same procedure as 431XM with additional physician work

required for the reconstruction of the bowel, colon interposition, and anastomosis. The physician work involved in 431XN is similar to a combination of CPT codes 43120 [Esophagogastrectomy (lower third) and vagotomy, combined thoracicoabdominal, with or without pyloroplasty, 26.35 RVW] and 44140 [Colectomy, partial; with anastomosis, 17.27 RVW].

431XP [Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy, 25.00 RVW], involves the removal of the esophagus without reconstruction. 431XP is the same work as a combination of CPT codes 43119-52 [Total esophagectomy with gastropharyngostomy, without thoracotomy, 27.50 RVW modified by -52] and 43352 [Esophagostomy, fistulization of esophagus, external; cervical approach, 11.04 RVW].

Codes 431XQ [Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty, 26.35 RVW] and 431XR [Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small bowel reconstruction, including mobilization, preparation, and anastomosis(es), 30.00 RVW], describe gastrointestinal reconstruction for previous esophagectomy. 431XQ describes this reconstruction in conjunction with the stomach; 431XR describes the reconstruction in conjunction with the colon. The RUC noted that these procedures are done without performing a thoracotomy. Code 431XQ would previously have been reported using code 43120 [Esophagogastrectomy (lower third) and vagotomy, combined thoracicoabdominal, with or without pyloroplasty, 26.35 RVW] with modifier-22, and the physician work is the same as 43120. The physician work of 431XR is based on a combination of CPT codes 43120, 44130 [Enteroenterostomy, anastomosis of intestine; (separate procedure), 11.21 RVW], and 44140 [Colectomy, partial; with anastomosis, 17.27 RVW].

431XU describes the ligation or stapling at gastroesophageal junction for a pre-existing esophageal perforation [15.00 RVW]. This procedure can be performed via laparotomy or thoracotomy. The physician work for 431XU is similar to CPT code 43331 [Esophagomyotomy (Heller type), with or without hiatal hernia repair); thoracic approach, 14.89 RVW].

Code 32820, major reconstruction of the chest wall, is also equivalent to 32100, thoracotomy, major, with exploration and biopsy, with 10.18 RVWs plus 15734, muscle, myocutaneouis, or fasciotuneous flap; trunk, with 16.70 RVWs [16.70 + .50(10.18)].

10. **Gastrotomy[Tab 21]**
RUC Tracking Numbers: G1 - G3
Presentation: Paul Collicott, MD, FACS, American College of Surgeons

There was considerable discussion of this issue. This issue was referred to a facilitation committee that will meet at the May RUC meeting. This committee will be chaired by Doctor Schnur. Other members are Doctors Hayes, Winters, Slachta, and Shapiro.

11. **Stomach Suture[Tab 21]**
RUC Tracking Numbers: H8, H10
Presentation: Paul Collicott, MD, FACS, American College of Surgeons
American College of Obstetricians and Gynecologists

This issue was also referred to the facilitation committee chaired by Doctor Schnur that will meet at the May RUC meeting.

12. **Rectal Surgery[Tab 23]**
RUC Tracking Numbers: I4, I9
Presentation; Paul Collicott, MD, FACS, Frank Opelka, MD, FACS
American College of Surgeons and American Society of Colon and Rectal Surgeons

The RUC developed recommendations for the new codes in this section. Revisions in existing codes were considered to be editorial and no change was recommended. Codes 4511X [Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy] and 4512X [Proctectomy, partial, without anastomosis, perineal approach] describe services which could not be reported using existing CPT codes. It is estimated that 4511X represents 80% of services previously reported as code 45112 [Proctectomy, combined abdominoperineal, pull-through procedure, 24.29 RVW] with modifier -22. The recommendation for 4511X is based on a survey of the colon and rectal surgeons who have the most experience with this procedure. This procedure is difficult as it requires preservation of the ileum and requires taking down the previous ileostomy in order to prepare the rectum for partial resection and subsequent anastomosis. Code 4512X is more difficult than 58150, total abdominal hysterectomy, because of extensive scarring from previous operation and the difficulty of post-operative wound management. This procedure would not be performed in the global period of the primary procedure, as it typically occurs at least six months later.

13. **Exploration and Drainage for Rectal Injury[Tab 24]**
RUC Tracking Numbers: J1, J2
Presentation: Paul Collicott, MD, FACS; Frank Opelka, MD, FACS
American College of Surgeons, American Society of Colon and Rectal Surgeons

The recommendations for 458XA and 458XB are based on a survey median of nearly 60 general surgeons and colon and rectal surgeons. Code 458XA [Exploration, repair, and presacral drainage for rectal injury] is more work than 43420 [Closure of esophagostomy or fistula; cervical approach] because the injury is more difficult to locate. This procedure is also more difficult than exploration of anal fissures or abscess as intra-abdominal exploration is frequently required. The RUC recommends 17.75 RVW for 458XB [Exploration, repair, and presacral drainage for rectal injury; with colostomy]. Not only is there additional work in performing the colostomy, but the significance of the injury that requires the colostomy to be performed makes the primary procedure more difficult. The RUC discussed the vignette used to survey for J2 and concluded that the typical patient undergoing this procedure would be a post-resuscitation patient in shock. There is a 5-6% mortality rate for these patients.

14. **Liver Surgery[Tab 25]**
RUC Tracking Numbers: K4, K5
Presentation: Paul Collicott, MD, FACS, American College of Surgeons

The RUC recommendation for the new code 4702X [Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cysts(s) or abscess(es)] is based on a comparison to codes 47010 [Hepatotomy for drainage of abscess or cyst, one or two stages] and 47300 [Marsupialization of cyst or abscess of liver], both with an RVW of 8.85. 4702X is slightly more work than 47010 and 47300 as more care is required to avoid spillage and to protect the remaining abdominal contents. 4702X is estimated to represent 1% of services previously reported with code 47010 and modifier -22, which had a 1992 Medicare frequency of 12.

The other coding revisions in this section were considered editorial and no change in relative value was recommended.

15. **Bile Duct Surgery[Tab 26]**
RUC Tracking Numbers: L7, L11, L12
Presentation: Paul Collicott, MD, FACS, American College of Surgeons

The RUC adopted recommendations for three new codes 4774X, 4778X, and 4790X based on a survey of general surgeons. Other coding revisions in this section were considered editorial and no change in relative value is recommended. 4774X [Cholecystoenterostomy; Roux-en-Y with gastroenterostomy] is performed on patients that have pancreatic and/or bowel cancer. During this procedure the Roux-en-Y loop is mobilized and anastomosis is performed. The recommended RVW of 16.41 for this procedure is less than the survey median and is calculated by adding the difference between the work involved in cholecystoenterostomy, direct (12.03) and Roux-en-Y (14.08) to the work of cholecystoenterostomy with gastroenterostomy (14.57). The recommended RVW is also higher than the reference services due to the additional work that is required to mobilize the Roux-en-Y loop and the additional anastomosis. Previously 4774X was reported as a multiple procedure using CPT codes 47740 [Cholecystoenterostomy; Roux-en-Y] and 43820 [Gastrojejunostomy] with modifier -51.

4778X [Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract] is performed primarily on patients with biliary cancer, as a secondary surgery on patients that have had previous resection of the of the common bile duct with anastomosis. During the secondary surgery the right and left hepatic ducts are anastomosed by developing a Roux-en-Y jejunal loop. The recommended RVW for 4778X of 24.48 is lower than the RVW of the key reference service for this code, which is 47701 [Portoenterostomy (eg, Kasai procedure), 26.87 RVW].

4790X [Suture of extrahepatic biliary duct for pre-existing injury (separate procedure)] is performed on patients that are septic due to advanced peritonitis and may also have extensive bowel injury. The recommended RVW of 15.80 falls in between RVWs for the reference procedures because 4790X involves more physician work than 47420 [Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy, 15.48 RVW], due to sepsis and bile drainage, but is less physician work than 47800 [Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis, 17.91 RVW] because the physician is not reconstructing the extrahepatic biliary ducts.

16. **Peritoneal Shunts[Tab 27]**
RUC Tracking Codes: M3, M6, M7
Presentation: Paul Collicott, MD, FACS, American College of Surgeons
American College of Obstetrics and Gynecology

The RUC recommendations for the peritoneal shunt codes were based on a survey of general surgeons and obstetricians/gynecologists. 4942X, 494XA, and 494XB are new codes that will adequately describe all of the aspects of peritoneal shunt management which were previously not identified in CPT.

4942X describes the removal of a permanent intraperitoneal catheter due to intractable infection of the vascular access site. The RUC recommended the adoption of 5.92 RVW for 4942X, which is comparable to the RVW of the reference service 62256 [Removal of complete CSF shunt system; without replacement, 5.97 RVW]. The RUC adopted an RVW that was higher than the reference service 49421 [Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent, 4.94 RVW] for this code because it was noted that removal of the catheter which involves dissection is more work than catheter insertion.

494XA describes the ligation of a peritoneal-venous shunt following the surgery for the placement of a peritoneal shunt. The ligation is recommended 5 days post-op if the shunt is rendered dysfunctional due to extensive bleeding. The recommended RVW for 494XA is lower than that of reference service 62256 [Removal of complete CSF shunt system; without replacement, 5.97 RVW], and comparable to reference service 32020 [Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)]. The recommended RVW 494XA is also higher than reference service 37700 [Ligation and division and complete stripping of long or short saphenous veins], because the underlying condition of the patient makes the procedure more complex.

494XB describes the removal of a peritoneal-venous shunt, a procedure that is performed due to shunt malfunction and/or infection. The RUC recommendations for ligation [494XA, 3.99] and removal

[494XB, 6.42] for peritoneal-venous shunt are both well below the current value of 8.67 for revision of peritoneal-venous shunt [49426].

17. **Endocrine Surgery[Tab 28]**
RUC Tracking Codes: P2, P3, P4
Presentation: Paul Collicott, MD, FACS; Charles Koopman, MD
American College of Surgeons, American Academy of Otolaryngology - Head and Neck Surgery, Inc.

The RUC adopted the recommendations for the endocrine surgery codes based on a survey of otolaryngologists and general surgeons. Additional descriptive information about this group of services was provided, and frequency information is provided on each of the attached recommendation forms. It is notable that for two of these services, codes 6000X and 6050X, the RUC is recommending changes in the estimated global periods.

6000X [Aspiration and/or injection, thyroid cyst] is a complicated procedure due to the risk of injury. The aspiration in the neck region puts the patient at risk for damage to the airways or great vessels. The work that is done for this procedure is very similar to CPT code 60100* [Biopsy thyroid, percutaneous core needle, 0.98 RVW]. The RUC noted that this procedure was also similar in nature to CPT code 19100 [Biopsy of breast; needle core (separate procedure), 1.30 RVW]. The RUC also compared the physician work for CPT code 88170 [Fine needle aspiration with or without the preparation of smears; superficial tissue (eg, thyroid, breast, prostate), 0.52 RVW] to 6000X, which would also be reported for the injection of sclerosing solution, a more complicated procedure than aspiration. Since 6000X would be reported for aspiration and/or injection the higher RVW is justified.

602XA [Partial thyroid lobectomy, unilateral; with or without isthmusectomy] involves working within the capsule that encases the thyroid gland. The patient has usually experienced difficulty in swallowing which is the result of a thyroid nodule that is surgically removed. The recommended RVW for 602XA is 10.63. The work that in done is 602XA, including the isthmusectomy, is more complicated than the most similar reference service 60220 [Total thyroid lobectomy, unilateral, RVW 9.97]. The work for 602XA is considered less complicated than 60245 [Thyroidectomy, subtotal or partial, 12.16 RVW], because the physician is not performing a partial thyroidectomy.

602XB [Partial thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy] is considered an extremely intense procedure. The surgeon must take special care not to damage the parathyroid. In addition the surgeon is performing this procedure bilaterally, including bilateral isthmusectomies. Increasingly, this operation is being performed on a younger patient population, usually as the result of Graves Disease. Patients who have Graves disease are usually free of the significant disease pathology to the organs that are near the thyroid and the surgeon must use extra precaution to ensure that these other organs are not damaged. It was noted that the patients put themselves at potentially great surgical risk by undergoing surgery as opposed to radiation therapy which may have been refused by the patient or was ineffective. The recommended RVW for 602XB is 15.65, which is slightly lower than 60240 [Thyroidectomy, total or complete, 15.83 RVW].

6050X [Parathyroid autotransplantation], is a new procedure that was previously reported using an unlisted CPT code. The patients that undergo this procedure are in renal failure complicated by hyperparathyroidism. This procedure is an add-on procedure to parathyroidectomy.

RUC recommendations for the new thymectomy codes are approximately work neutral. Codes 60520 [revised to read Thymectomy, partial or total; transcervical approach (separate procedure)] and 605XA [Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)] are reported according to the specific approach that the surgeon took to perform the operation. Both 60520 (16.00 RVW) and 605XA (18.00 RVW) are similar in work to the key reference service, which is code 60520 prior to revision [Thymectomy, partial or total (separate procedure), 17.30 RVW]. The difference in the RVW is based on the complexity of the approach, with a transcervical approach rated less difficult than a sternal split. 605XB is also a code for thymectomy that is performed via sternal split or transthoracic approach. The RVW for 605XB is greater than that of 60520 and 605XA because the surgeon is also performing a radical mediastinal dissection.

18. **Transplant Surgery**

CPT Code Numbers 50300, 33940, 33930, 47133, 48550, 33935, 33945, 47135, 471XB, 48550, 48554, 48556

Recommendations for transplant procedures were included in multiple tabs within the RUC agenda book. In addition, the Society of Thoracic Surgeons requested that recommendations previously adopted by the RUC for two transplant procedure codes 39930 and 39940 be reconsidered so that the survey data from the membership of the American Society of Transplant Surgeons (ASTS) could be incorporated in the RUC recommendations for these codes. A facilitation committee chaired by Doctor Moorefield agreed to reconsider the codes.

A facilitation committee was then formed with Doctor Gage as Chair to consider the relative value recommendations for all of the transplant procedures on the agenda. The committee met with representatives from involved specialties and from the ASTS, including Doctors James Burdick, David Sutherland, and William Baumgartner. The facilitation committee developed recommendations for the cadaver donor transplant procedures (50300, 33940, 33930, 47133, 48550) using estimates of time and intensity for each service. The committee adopted the specialties' recommendations for all of the other transplant procedure codes (33935, 33945, 47135, 471XB, 48550, 48554, 48556).

The ASTS representatives indicated that they would accept the facilitation committee's recommendations and the RUC adopted the facilitation committee report. A minority view was expressed by Doctor Slachta that the cadaver donor code recommendations lacked face validity. Copies of the complete recommendations of the facilitation committee and the RUC have been previously distributed.

19. **Diaphragm[Tab 29]**

CPT Tracking Numbers: V1, V2, V4, V5
American College of Surgeons, Society of Thoracic Surgeons

This issue was withdrawn by the specialty societies because all of the CPT changes are considered editorial.

20. **Esophagogastrostomy[Tab 30]**

CPT Tracking Numbers: X1, X2

American College of Surgeons, Society of Thoracic Surgeons

This issue was withdrawn by the specialty societies and will be referred back to the CPT Editorial Panel.

21. **Esophageal Repair[Tab 31]**
CPT Tracking Numbers: Z1, Z2, Z3, Z4,
American College of Surgeons, Society of Thoracic Surgeons/American Association for Thoracic Surgery, American Academy of Otolaryngology - Head and Neck Surgery, Inc.

This issue was withdrawn by the specialty societies because all of the CPT changes are considered editorial.

## X. Other Issues

At the November RUC meeting, Mr. Bernie Patashnik had indicated that HCFA was working to develop plans for the five-year review of the RBRVS. Subsequently, in a meeting of AMA and HCFA staff, HCFA requested that the AMA and the RUC develop a "concept proposal" by mid-March outlining organized medicine's interest in and thoughts on how the five-year review should be conducted. On Sunday morning, Doctor Rodkey announced the formation of a new RUC Subcommittee on the Five-Year Review to work with AMA staff in developing this proposal. Doctor Tudor was appointed to chair the subcommittee and the other members appointed were Doctors Gage, Graham, Hanley, Kwass, Maves, Moorefield, Ogrod, and Slachta. This subcommittee held an initial meeting on Sunday at the conclusion of the RUC meeting.

Doctor Rodkey distributed and discussed a letter he received from Doctor Bristow, who wrote on behalf of the AMA Board of Trustees to respond to the three recommendations to the AMA that were adopted by the RUC at its November meeting. The letter indicated that the Board had adopted the recommendations and asked the AMA General Counsel's Office to explore how the RUC's concerns could be integrated in the AMA's health system reform efforts.

A request was received from the American College of Rheumatology for the RUC to reconsider its recommendation for code 75075 for DEXA. **A facilitation committee chaired by Doctor Hanley agreed to reconsider the recommendation at the May RUC meeting.**

**The RUC approved three motions requesting that staff prepare the following items for the Research Subcommittee's review:**

**1)an annotated list of RUC actions;**

**2) guidelines for developing compelling evidence; and**

**3)an insert for the Instructions to Specialty Societies and recommendation form to inform those conducting surveys that they may request other relevant information from survey respondents and provide for this additional information to be given to the RUC.**