

**AMA/Specialty RVS Update Committee
January 31, 2002 – February 3, 2002**

**The Pointe at South Mountain
Phoenix, Arizona**

I. Welcome and Call to Order

Doctor James G. Hoehn called the meeting to order on Friday February 1, 2002 at 8:00 a.m. The following RUC members were in attendance.

James G. Hoehn, MD, Chair	John E. Mayer, Jr., MD
James Blankenship, MD	David L. McCaffree, MD
James P. Borgstede, MD	Bill Moran, Jr., MD
Melvin C. Britton, MD	Bernard Pfeifer, MD
John Derr, Jr., MD	Louis Potters, MD*
Lee D. Eisenberg, MD	Gregory Przybylski, MD
John O. Gage, MD	Sandra B. Reed, MD*
William F. Gee, MD	William Rich, MD
Meghan Gerety, MD	Peter Sawchuck, MD*
Alexander Hannenberg, MD	Chester W. Schmidt, Jr., MD
James E. Hayes, MD	Joseph Schwartz, MD*
David F. Hitzeman, DO	J. Baldwin Smith, III, MD
Charles F. Koopmann, Jr., MD	Sheldon B. Taubman, MD
Steven E. Krug, MD*	Trexler Topping, MD*
M. Douglas Leahy, MD*	Arthur Traugott, MD*
Barbara Levy, MD	Paul E. Wallner, DO
J. Leonard Lichtenfeld, MD	Richard Whitten, MD
Charles D. Mabry, MD*	Don E. Williamson, OD
James D. Maloney, MD*	

* Alternate

II. Chair's Report

Doctor Hoehn welcomed the RUC members and addressed the following issues:

- Discussion ensued about the postponement of the September 2001 RUC meeting. Doctor Hoehn asked RUC members to rise for a moment of silence to honor the people who had lost their lives in September 11th attacks.
- Doctor Hoehn welcomed and announced the following 10 new RUC members:
 - James Borgstede, MD – American College of Radiology
 - Melvin Britton, MD – American College of Rheumatology
 - Neil Brooks, MD – American Academy of Family Physicians

John Derr, MD – American Society of Plastic Surgeons
Meghan Gerety, MD – American Geriatric Society
Bernard Pfeifer, MD – American Academy of Orthopedic Surgeons
Greg Przybylski, MD – American Academy of Neurological Surgeons
Richard Tuck, MD – American Academy of Pediatrics
Paul Wallner, MD – American Society of Therapeutic Radiology Oncology
J. Baldwin Smith, MD – American Academy of Neurology

Acknowledgements

- John Gage, MD has been elected Secretary of the American College of Surgeons
- Paul Collicott, MD has been elected Director of Member Services of the American College of Surgeons
- Michael Maves, MD, a former RUC member representing the American Academy of Otolaryngology – Head and Neck Surgery, has been selected to be the EVP/CEO of the American Medical Association. Doctor Maves has been invited to address the RUC and has indicated that he will attend either the April or September RUC Meeting
- William Gee, MD has been selected to represent the RUC on the CPT Editorial Panel Evaluation & Management Work Group. Doctor Gee has already attended the first meeting and will give his report in the CPT update.

Doctor Hoehn announced the members of the four facilitation committees, as follows:

Facilitation Committee 1

Charles Koopman, Jr., MD,
(Chair)
James Blakenship, MD
John Gage, MD
Alexander Hannenberg, MD
John Mayer, Jr., MD
Greg Przybylski, MD
J. Baldwin Smith, MD
Paul Wallner, DO
William Peruzzi, MD
Karen Smith, MS, RD

Facilitation Committee 2

James Hayes, MD, (Chair)
James Borgstede, MD
John Derr, Jr., MD
Meghan Gerety, MD
Barbara Levy, MD
David McCaffree, MD
William Rich, MD
Sheldon Taubman, MD
Richard Whitten, MD
Gary Seabrook, MD
Mary Foto, OTR

Facilitation Committee 3

J. Leonard Lichtenfeld, MD,
(Chair)
Melvin Britton, MD
Lee Eisenberg, MD
William Gee, MD
David F. Hitzeman, DO
Steal King, MD
Bill Moran, MD
Bernard Pfeifer, MD
Chester Schmidt, Jr., MD
Don Williamson, OD

Facilitation Committee 4

John Gage, MD, (Chair)
Meghan Gerety, MD
Alex Hannenberg, MD
J. Baldwin Smith, MD
Sheldon Taubman, MD
Bernard Pfeifer, MD
Arthur Traugott, MD

III. Director's Report

- Patrick Gallagher announced that under Tab 2, there is a listing for the upcoming RUC meetings, which have been coordinated with the CPT and PEAC meetings
- The 2002 Medicare RBRVS Physician's Guide has been published and all RUC members are welcome to have a copy. To have a copy delivered, contact the AMA staff
- Introduction of New Staff
 - Julie Powers – Council Committee Coordinator
 - Roseanne Eagle – Senior Policy Analyst
 - Monica Horton – Senior Policy Analyst
- The new RUC 2002 database is available through Todd Klemp.

IV. Approval of Minutes for the April 26-29, 2001 RUC Meeting

The minutes of the April 26-29, 2001 RUC meeting were approved with the following revisions:

A typo on page 70 was corrected. The 1st quintile of the Anesthesia Intensity Factors should read:

- 0.0224 not 0.224.
- Revisions were made to the 2002 RUC recommendations physician time approved at the April 2001 RUC meeting. The discharge day management time for codes 24300, 24322, 24332, 24343, 24344, 24345, 24346, 25001 should read 18 minutes. In addition, the discharge day management times for codes 43313, 43314, 44127 should read 45 minutes.
- The term "unvalidated" on page 9 of the minutes was discussed. Sherry Smith described this term to be used when a code that has been considered by the RUC at one meeting and an interim recommendation approved. The specialty society is then asked to come back to the next meeting with new data to

substantiate their previous recommendation. If the specialty society chooses not to present new data, the RUC would send a letter to CMS that the previous recommendation was “unvalidated.”

- Other questions were raised regarding the Administrative Subcommittee Report. Doctor Gage asked AMA Staff to clarify whether the vignettes utilized in CPT coding products were updated to be consistent with the RUC summary of recommendation forms. AMA staff clarified that this information is indeed updated. Doctor Gage also questioned whether specialties could also utilize these vignettes in specialty society products. AMA staff noted that the CPT proposal forms notify that all CPT proposed information is under copyright of the AMA. Specialties should contact CPT Licensing for further information.

V. CPT Update

Doctor Hoehn made the announcement that he would be representing the RUC at the CPT February meeting.

Doctor Lee Eisenberg provided the RUC with a recent update regarding the “With or Without” issue. It was announced that 20% of the “With or Without “ codes will be done through each CPT cycle. Specialty societies will determine whether they wish to support a change to these codes.

Doctor Gee gave a brief description of the CPT Editorial Panel Evaluation and Management Work Group. The Work Group was created by the AMA House of Delegates to try to solve the issues and concerns associated with E & M Documentation and Guidelines. The E & M Work Group, chaired by Doctor Douglas Wood of the Mayo Clinic, consists of 21 members. The composition of the group includes representation from the RUC, the AMA, various carrier medical directors, CMS and other physicians from various specialties. There will be five meetings between January and June. The goal of this group is to develop recommendations to solve the various issues associated with the E & M Guidelines and send preliminary recommendations to the CPT Editorial Panel in August.

Several aspects of the E & M work group were then discussed including:

- The ramifications of a change in the number of levels of service. A Member of the RUC expressed their concern that any change to the Evaluation & Management codes or the guidelines will create substantial disruptions to physician practices.
- Specialty representation- Doctor Gee made it clear that the issue of non-represented specialties on the E & M workgroup was discussed and gave assurance that these specialties would be given a chance to testify in the near future.

VI. CMS Update

Doctor Paul Rudolf and Carolyn Mullen made the following comments:

- Carolyn Mullen provided the RUC with an update of several pending studies. The OIG study on physicians' clinical staff in the facility is in draft form and therefore, CMS is unable to discuss it at this time. Additionally, the GAO report on the practice expense refinement is just beginning and a draft report is due out this spring.
- Doctor Rudolf addressed the issue of some physicians not receiving payment for pre-operative evaluation. He explained that carriers who are denying payment to these physicians have developed a policy to not pay for visits when the sole purpose is for a pre-operative evaluation. These carriers support their policy on Medicare statute 1862A7, which says that Medicare will not pay for routine exams. CMS has addressed this matter by issuing a program memorandum stating that they are no longer able to continue denying payment for these claims. However, it was noted that carriers could still deny payment of these claims by stating that they were medically unnecessary.
- Doctor Rudolf continued by informing the RUC that CMS is trying to determine how many claims are denied on the basis of being medically unnecessary. He also stated that CMS was determining whether to issue a national coverage decision on pre-operative evaluations, which may help address this issue.
- Doctor Rudolf addressed concerns about the increasing costs of Practice Liability Insurance (PLI). He addressed questions about the process of updating these values, the significant increases in PLI nationally and suggested that if there was further concern about PLI that the specialty society should draft a letter to the CMS administrator describing their particular concern. Patrick Gallagher informed the RUC that the AMA has formed a taskforce, which has enlisted the help of specialty societies and state societies to tackle the problems with PLI costs. The Advocacy Resource Center in Chicago and the Washington Staff are working with the states and specialties to collect and assess data regarding PLI increases.
- Doctor Rudolf indicated that the Health Economics Research (HER) report will be published on the CMS web site between February 4th and February 15th. This report will be presented to the RUC at the April Meeting and will be a part of the discussion at the next E & M Work Group meeting
- Doctor Rudolf informed the RUC that if the AMA or any specialty society want CMS to review any specific topic in the upcoming Proposed Rule, they should contact CMS in writing.

VII. Relative Value Recommendations for CPT 2002:

Therapeutic Injections (Tab 5)

Presenters: Karl E. Becker, MD, American Society of Anesthesiologists; J. Baldwin Smith, MD, American Academy of Neurology; and Charles Mick, MD, North American Spine Society

The RUC reviewed this issue and convened a detailed discussion regarding the work relative value recommendations and survey data, as presented. The RUC had significant concerns regarding the survey process utilized and the lack of cross-specialty validation. Several other specialty societies came forward after these recommendations were developed to express an interest in developing a larger coalition of specialties to review these services. The RUC, therefore, referred this issue to an Injection Workgroup who will pre-facilitate the recommendations developed by the larger coalition at the April RUC meeting. The Injection Workgroup is comprised of the following RUC members and Advisors:

William Rich, MD (Chair)	American Academy of Ophthalmology
Karl Becker, MD	American Society of Anesthesiologists
James Borgstede, MD	American College of Radiology
Melvin Britton, MD	American College of Rheumatology
John Derr, Jr, MD	American Society of Plastic Surgeons
Meghan Gerety, MD	American Geriatrics Society
Charles Koopmann, MD	American Academy of Otolaryngology – Head and Neck Surgery, Inc.
Marc Lenet, DPM	American Podiatric Medical Association
David McCaffree, MD	American Academy of Dermatology
Charles Mick, MD	North American Spine Society
Daniel Nagle, MD	American Society for Surgery of the Hand
Bernard Pfeifer, MD	American Academy of Orthopaedic Surgeons
J. Baldwin Smith, MD	American Academy of Neurology
To be Identified	American Academy of Physical Medicine & Rehabilitation

Elbow Surgery (Tab 6)

Presenter: Dan Nagle, MD, American Society for Surgery of the Hand

Two new elbow surgery codes were established to identify newly developed surgical techniques, codes 24344 *Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)* and 24346 *Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)*. At the April 2001 RUC meeting, the RUC assigned interim value recommendations due to the lack of survey data. The specialty societies then collected survey data for these codes and presented their results at the February 2002 RUC meeting. The RUC believed the physician work associated with code

24344 and code 24346 were similar to the work associated with code 27428 *ligamentous reconstruction (augmentation), knee; intraarticular (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
- CPT code 24346 and 27428 both require an arthrotomy. CPT code 24344 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.

In addition, previous RUC survey data for 24343 *Repair lateral collateral ligament, elbow, with local tissue* (work RVU= 8.64) and 24345 *Repair medial collateral ligament, elbow, with local tissue* (work RVU = 8.64) indicated the physician work values are appropriate for these primary repairs. These values are the same as code 27405 *Repair, primary, torn ligament and/or capsule, knee; collateral* (work RVU=8.64). However the increase in complexity inherent in the reconstruction of the collateral ligament of the elbow and knee are similar.

The RUC therefore recommends relative work values of 14.00 for CPT codes 24344 and 24346.

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for CPT codes 24344 and 24346. 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 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/MTA 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 attached to these recommendations.

Ablation of Hepatic Tumors (Tab7)

**Presented by: James P. Borgstede, MD, American College of Radiology
Bibb Allen, Jr. MD, American College of Radiology,
Charles Mabry, MD, American College of Surgeons
Robert L. Vogelzang, MD, Society of Cardiovascular and
Interventional Radiology**

Reviewed by: Facilitation Committee #1

Three new surgery codes, two new laproscopic codes, and three new radiologic guidance codes were created for the ablation of hepatic tumors. The RUC recommends that the work for code 47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency* should be evaluated as follows:

Pre-Service	30 minutes x 0.0224	0.66
Intra-Service	180 minutes x 0.071	12.78
Same day post	30 minutes x 0.0224	0.66
½ discharge day management		0.64
Office visit (99212)		<u>0.45</u>
Total Work RVU		15.19

The committee agreed that this service was as least as intense as cryosurgical ablation of the prostate (IWPUT=0.71) and that the total work of code 55873 (February 2001 RUC recommendation = 19.47) is comparable to (or less than) the total work of the ablation of the liver tumor 47382, when the radiologic guidance code (76362, 76394, or 76490) is added to this code.

The RUC recommends a relative work value of 15.19 for CPT code 47382.

Using a building block method for all other codes, values were determined using the 15.19 work RVU for 47382. The code 47370 *Laproscopy, surgical, ablation of one or more liver tumor(s); radiofrequency*, has a 090 day global period, and therefore requires 3 full hospital visits (99232, 99231, and 99238), and two additional office visits (2x 99213) when compared to 47382. Code 47371, *Laproscopy, surgical ablation of one or more liver tumor(s); cryosurgical* also has three full hospital visits, and two additional office visits (2x 99213). The median intra-operative time for both procedures is 180 minutes, and the resulting IWPUT for both procedures is 0.071. Therefore, the RUC determined that the work RVU for 47370 and 47371 should be the same.

The RUC recommends a relative work value of 19.69 for both CPT codes 47370 and 47371.

In addition to the two laproscopy codes, the RUC discussed and reviewed open ablation codes, 47380 *Ablation, open, of one or more liver tumor(s); radiofrequency* and 47381 *Ablation, open, of one or more liver tumor(s); cryosurgical*. Surgical procedures 47380 and 47381 are also 90 global procedures. Based on the survey results, the RUC believed that the intra service work intensity

for these open ablation codes was slightly less than the above mentioned laproscopy ablation codes (IWPUT = 0.061). However, the RUC agreed that these procedures required 5 full hospital visits (2 x 99232, 2 X 99231, and 1 x 99238), and 2 additional office visits (2x 99213 and 1x 99212) when compared to 47382. The RUC was careful to maintain relativity among the group of codes and with similar procedures.

The RUC recommends a relative work value of 23.00 for CPT code 47380 and 23.27 for CPT code 47381.

The RUC reviewed radiologic guidance codes 76362, 76394, and 76490, and determined that the relative values as presented by the specialty societies (SCVIR, ACR, and ACS) are appropriate. The RUC agreed that a second physician may perform the radiologic guidance and that the intensity is less than an E/M intensity of 0.31. The RUC also compared an intensity of 0.026 per minute with the time fore each of these services.

The RUC recommends a relative work value of 4.00 RVUs for CPT code 76362, 4.25 RVUs for CPT code 76394, and 4.00 RVUs for CPT code 76490.

Practice Expense

The practice expenses for 47370- 47381 were approved with the removal of the patient education booklet. The practice expense for 47382 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 76362-76490, as these services are performed in a facility setting only. For medical supplies for 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 attached to these recommendations.

Digitization of Mammographic Filming (Tab 8)

Presented by: Bibb Allen, Jr., MD, American College of Radiology

In *CPT 2002*, a code was created to describe the additional work of digitization of film radiographic images with computer analysis for lesion detection. CPT code 76085 is appended to 76092 *Screening mammography, bilateral (two view film study of each breast)* when this new technology is utilized. The RUC agreed that there is minimal additional physician work related to this service and agreed with the specialty's recommendation of 0.06. This work relative value is consistent with the work relative value implemented for this code by the Centers for Medicare and Medicaid Services on January 1, 2002.

The RUC recommends a work relative value of 0.06 for CPT code 76085.

The RUC also reviewed the direct practice expense inputs associated with this service and made no modifications to the inputs as proposed by the specialty and appended to this recommendation. There are no direct practice expense inputs when this service is performed in an out-of-office setting.

Intracardiac Electrophysiology – Mapping, Comprehensive EP, & Analysis of Pacing Cardioverter Defibrillators (Tab 9)

Presented by: James Maloney, MD, American College of Cardiology

Reviewed by: Facilitation Committee #3

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. All of these codes were reviewed by the RUC in April, 2001. At that time, codes 93609 and 93613 were referred back to CPT for clarification and the CPT Editorial Panel clarified that these services should be add-on codes. CMS valued these codes for 2001 without input from the RUC.

93609 Intraventricular and/or intra-atrial mapping of tachycardia site(s) with 3 dimensional mapping or catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)

The RUC discussion focused on ensuring that these codes were appropriately valued as add on codes and did not contain any pre and post service work. The RUC was concerned that the survey respondents inappropriately included additional work in their estimates and therefore adjusted the recommended values to reflect only the intra-service work. The intra-service time of the base code 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* (11.59 RVW) was examined to determine the incremental time of mapping attributed to 93609 that is separate from the base code. The RUC felt that the proposal of 7.20 RVUs for 93609 was based on the inclusion of some of the work of the base code 93620, and therefore was an overestimation of the work.

The RUC also examined the CMS rationale for valuing this code at 4.81 RVUs, which is equal to code 93624 *Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia* (4.81 RVW) with an intra-service time of 60 minutes. The committee felt that that 93624 had less intensity than 93609 and was not an appropriate comparison. However, code 93618 *Induction of arrhythmia by electrical pacing* has time of 90 minutes with work RVU of 4.26 was a better comparison but also was determined to have less intensity.

The RUC felt that another methodology for reducing the recommended RVU so that it only includes intra-service work is to assign an IWPUT of .066 to 93609, which is less than the IWPUT of .07 and .08 for other codes in the family. Using

this IWPUT and the survey time of 90 minutes, results in the following value: $90 \times .066 = 5.94$

The value is then reduced by 15% to account for duplication of time with the base code, resulting in an RVU of 5.00.

The RUC recommends a work RVU of 5.00 for 93609.

93613 *Intracardiac electrophysiologic 3-dimensional mapping* (List separately in addition to code for primary procedure)

The RUC reviewed this code in conjunction with 93609 and had the same concerns described above. The RUC therefore felt that the survey 25th percentile of 7.00 RVUs is appropriate since this is more intense than 93609 and the resulting work RVU accounted for any duplication with the base code. This value also places the code in proper rank order.

The committee recommends a work RVU of 7 for 93613.

Practice Expense

Since codes 93609 and 93613 are add on codes performed in the facility setting there are no direct practice expense inputs for these codes.

Gait and Motion Analysis (Tab 10)

Presenters: David Martin, MD, American Association of Orthopaedic Surgeons

Five codes were created to describe more accurately the comprehensive motion analysis studies. **96004**, *Physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report*, was created specifically to describe the work done by the physician in interpreting the motion analysis study.

The RUC examined the survey results for code 9600X5 and had some concerns about the difference between the specialty society's recommended work value and their reference service code 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family* (work relative value of 2.67). The RUC noted that the reference code and new code had similar physician work. In addition, the RUC noted that the reference code had additional time. The RUC

then made a recommendation to use a ratio of the new code's total time to the reference code's total time and then multiply this ratio by the reference code's RVW to get the recommended work value for this code.

The RUC recommends a work relative value of 2.14 for CPT code 96004.

Practice Expense:

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

VIII. Relative Value Recommendations – Requests from CMS:

Screening Mammography (Tab 11)

Presenter: Bibb Allen, Jr., MD, American College of Radiology

Reviewed by: Facilitation Committee #2

The RUC extensively discussed the survey data and comparisons of CPT 76092 *Screening mammography, bilateral (two view film study of each breast)* with other services (with similar service times or work RVU's similar to that requested). However, the RUC found that there was a disparity between the perceived service and the information available. Based upon the information available, the specialty society had difficulty sustaining an argument for its recommended work relative value of 0.70 to the Facilitation Committee and the RUC. The Facilitation Committee could not determine a reasonable and defensible methodology for delineating a relevant work RVU. The consensus was that the information available was not fully adequate and additional information should be collected regarding physician work related to the unique quality assurance aspects of this service. The RUC recommended that 76092 be resurveyed by interested specialty societies for presentation at the April RUC meeting, and that the specialties work with AMA RUC staff regarding the survey instrument and vignette development for the service.

The RUC adopted the direct practice expense inputs as presented by the specialty society.

IX. Relative Value Recommendations for CPT 2003:

Anesthesia for Closed Procedures on Cervical/Thoracic/Lumbar Spine (Tab 12)

Presented by: Karl Becker, MD, American Society of Anesthesiologists

0064X Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine

CPT created this code so that the anesthesia services provided in conjunction with CPT code 22505 *Manipulation of spine requiring anesthesia, any region* can be accurately reported. The RUC examined the survey results and agreed with the ASA analysis that the results of the survey intensity/ complexity measures

supports a base unit value lower than both reference services' base unit values due to the decreased work associated with the absence of surgical incision and supine positioning. Since the median survey value of 4 base units would create rank order anomalies and was not supported by intensity/complexity measures obtained via survey, the RUC agreed that a base unit of 3, the lowest number of base units assigned to anesthesia codes, was appropriate.

The RUC recommends a base unit value of 3.00 for CPT code 0064X.

Anesthesia Services for Diagnostic or Therapeutic Nerve Block Injections (Tab 13)

Presented by: Karl Becker, MD, American Society of Anesthesiologists

019X1 Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position.

019X2 Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); in the prone position

The RUC examined these two new codes together to ensure proper relativity. These codes were created to describe the work involved in delivering the typical anesthesia service for nerve blocks or injections performed by another provider. The difference between the codes is the patient's position, with the prone position entailing more work and risk. The ASA and RUC agreed that the median survey base unit values were not supported by the survey intensity and complexity measures. Therefore, the RUC agreed with the ASA recommendation of base units below the median values, so that they would be in proper rank order with other anesthesia services. The RUC felt that a base unit of 3 for 019X1 was appropriate since a number of similar less invasive anesthesia procedures are valued at 3 base units. Assigning 5 base units to 019X2 is equivalent to the base units assigned to more invasive anesthesia procedures.

The RUC recommends a base unit value of 3.00 for CPT code 019X1.

The RUC recommends a base unit value of 5.00 for CPT code 019X2.

Mohs Micrographic Surgery (Tab 14)

Presenters: Brett Coldiron, MD and Dan Siegel, MD, American Academy of Dermatology, American College of Mohs Micrographic Surgery and Cutaneous Oncology.

The presenters stated that the CPT changes to the family of Mohs codes was strictly editorial to clarify the intent of the codes and the coding for specimens and stains. For code 17310, the coding change allows for the reporting of each additional specimen after the first five specimens as opposed to the old descriptor that called for the reporting of more than five specimens. CMS contended that the

changes were not editorial. The AAD presenters explained that for large specimens account for about 5% of the cases and therefore the add on codes are used to report each specimen. Previously, the add-on code would be reported only once for any number of specimens greater than the first five. The AAD presenters stated that 17310 has always been billed for each additional specimen after the first five specimens as opposed to a one time add-on after the first five specimens. The presenters that CMS has reimbursed according to this interpretation and therefore it is only an editorial change, however after review of a 1992 Federal Register, the description indicated that the code should only be billed for one or more additional specimens above the first five specimens.

The RUC approved the following motions for this group of codes:

- **The change to code 17310 is not an editorial change and the RUC needs to evaluate the appropriate work value for 17310.**
- **The RUC requests the specialty to come back with survey results and a recommended work RVU for code 17310 in April, 2002.**
- **The RUC approves that the revisions to the descriptor for 17304 does not change the assigned work RVU.**
- **The RUC approved the work values for codes 17305, 17306, and 17307 since there is no change in the descriptors.**
- **The RUC does not approve the practice expense recommendations by the specialty. The RUC therefore requests the specialty to present revised recommendations at the April, RUC meeting for codes 17304 through 17310.**

Excision of Mandible/Facial Bone Tumor (Tab 15)

No specialty society presentation

The American Association of Oral and Maxillofacial Surgeons requested that CPT Codes 21030 – 210X4 be withdrawn due to insufficient response to the survey. These codes will be presented at the April 2002 RUC Meeting.

Venipuncture (Tab 16)

Presenter: Richard Dickey MD, The Endocrine Society

Doctor Dickey of the Endocrine Society requested additional time to refine the practice expense recommendations for the venipuncture codes. The recommendation from the specialty society for these codes is for practice expense only, since there is no physician work. The presenter suggested that the family of codes should be expanded to include the codes that are scheduled to be presented to the PEAC. Since additional venipuncture codes (36400, 36410, 36405, 36406) are currently scheduled to be presented to the PEAC in September, 2002, the RUC agreed that it would be beneficial to review the practice expense inputs for

all of these codes at the same time. However, since these codes new codes are transitioning to CPT, they need to be reviewed by April 2002. The RUC therefore directed the specialties that will be involved in the venipuncture presentation to the PEAC do review the codes at the March meeting as opposed to the September meeting, and present inputs for the venipuncture G codes that are transitioning to CPT at that time. Codes 36415, 3641X, and 36540 should therefore be added to the PEAC March agenda.

Therapeutic Apheresis (Tab 17)

Presenters: Samuel M. Silver, MD, American Society of Hematology
Reviewed by: Apheresis Therapy Workgroup Doctors Richard Whitten (Chair), Lee Eisenberg, Meghan Gerety, Leonard Lichtenfeld, John Mayer, William Rich, Mel Britton, and Emil Paganini.

The RUC referred this issue to an Apheresis Therapy Workgroup. The workgroup met to review issues related to the new and revised CPT codes related to apheresis and the submissions from the American Society of Hematology on work and practice expense.

The workgroup reviewed the history of CPT code changes related to apheresis, specifically including the addition of 36521 (made several years ago), to enable identification of the substantially increased costs related to the addition of an adsorption column. Current codes are:

36520 Therapeutic apheresis; plasma and/or cell exchange

36521 Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion

It was clear to the discussants that though some of the proposed codes (esp. 3651X1, 3651X2 and 3651X3) were for defined, uniform clinical situations, others apply to a diversity of situations some of which appear to require greatly more work (and possibly practice expense) than others.

Among the presenters, the members, and Dr. Eisenberg and Ms. Kotowicz representing CPT, it was agreed that the vignettes should be re-written, splitting out all evaluation and management components. Using dialysis service codes as a model, evaluation and management codes would be separately reported, when performed.

Other specialties provide or overview a substantial portion of these codes. Especially, input from rheumatology/immunology and nephrology were missed and it is hoped these specialties will be participative:

- a) in the preparation of more appropriate vignettes which separate out the E&M components,
- b) in the development and conduct of a re-survey, and

- c) in discussions with the workgroup as a pre-facilitation committee to develop a recommendation for the RUC

The workgroup recommended that the specialties petition CPT to include a note in the CPT text to specifically state that evaluation and management services should be reported separately. The workgroup recommended that this change occur in the same coding cycle as the work re-evaluation (ie, at the February CPT meeting if the intention is to re-survey for the April RUC meeting; or at the May CPT meeting if the work is to be presented in the CPT 2004 cycle). In addition, the workgroup recommended that a global period of XXX is more appropriate for these services than a 000 global.

Finally, the workgroup suggests that the specialties coordinate with all interested parties and prepare direct practice expense inputs for presentation at the April RUC meeting. The workgroup recommends that an initial review of this data be conducted via conference call with the workgroup participants and the presenters prior to the April meeting.

Fibrin Sheath/Intraluminal Mechanical Removal of Obstruction for Central Venous Devices (Tab 18)

Presented by: Bibb Allen, Jr., MD, American College of Radiology, and Robert Vogelzang, MD, Society for Cardiovascular and Interventional Radiology

Reviewed by: Facilitation Committee #1

Four new codes were presented to the RUC to describe the physician work associated with the maintenance of central venous devices. While CPT currently contains codes for introducing, revising, and removing central venous access devices, the work associated with the maintenance of the devices is not represented. The options for maintenance include stripping the fibrin sheath from/about the existing catheter or clearing obstructive material with a mechanical device under imaging guidance. The RUC discussed in detail the use of these codes and focused on identifying any possible overlap in physician work between the procedure codes and the related supervision and interpretation code.

The RUC felt that the specialty recommendation for CPT code 3653X1 (V1) value of 4.83, overstated the physician work, and was not supported by the survey data. Therefore, the RUC looked at two different methods of developing RVUs including assigning the IWPUT values to the survey time, and comparing the survey time with the time for existing codes. The RUC felt that the pre-service work had an IWPUT similar to evaluation and management codes, and an intra-service IWPUT similar to there codes in the family. As a result, the RUC agreed to the following value:

3653X1 (V1)

Intra .06 x 45 = 2.7

Pre .03 x 30 = .9

Total 3.6 RVW

In addition to devising a work RVU using IWPUR values, the RUC also examined CPT code 3653X1 in relation to the reference service CPT code 37203 *Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g., fractured venous or arterial catheter)* (work RVU = 5.03). CPT code 3653X1 had a lower pre-service time and intra-service time in comparison to code 37203, therefore the RUC felt that a reduction of approximately 30% from the reference service value of 5.03 would be warranted, thereby resulting in an approximate work value of 3.60. Given the various methodologies producing similar results, the RUC agreed that a work value of 3.60 is appropriate and placed the code in proper rank order.

The RUC recommends 3.60 work RVUs for CPT code 3653X1.

3653X2 (V2)

The RUC examined a number of comparable codes such as code 51600 *Injection procedure for cystography or voiding urethrocytography* (work RVU = 0.88) and code 23350 *Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography* (work RVU = 1.00). In comparison to reference code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (RVW = 0.76), the work is similar. The RUC felt that CPT code 3653X2 should be valued less than codes 51600 and 23350, and about the same as code 50394. The intra-service time for 3653X2 was reduced from 10 minutes to 9 minutes, to account for overlap between the procedure and the supervision and interpretation services.

The RUC recommends a work RVU of 0.75 for CPT code 3653X2.

759X1 (V3)

In comparison to the reference code 75978 *Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation* (RVW = 0.54), the work for 759X1 was slightly lower. The RUC agreed that code 75900 *Exchange of a previously placed arterial catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation* (work RVU = 0.49) was a comparable service and 759X1 should involve the same amount of work. The intra-service time was reduced from 15 minutes to 9 minutes.

The RUC recommends a work RVU of 0.49 for CPT code 759X1.

759X2 (V4)

The reference code 75820 *Venography, extremity, unilateral, radiological supervision and interpretation* (RVW = 0.70) has a total Harvard time that is less than code 759X2. In addition, in relation to code 759X1, CPT code 759X2 is about the same in terms of overall time. To maintain the relativity between the supervision and interpretation codes in this code family, the RUC wanted to retain the original specialty recommended differential between 759X1 and 759X2. Therefore the RUC agreed that 759X2 should be valued at 80% of 759X1.

The RUC recommends a work RVU of 0.39 for CPT code 759X2.

Practice Expenses

The RUC made a number of changes to the practice expense staff inputs. Primarily the RUC reduced phone calls to the 3-minute standard and deleted post service time in the facility setting, except for one 3-minute phone call. In addition, the specialty deleted a number of supplies. The revised direct PE inputs are attached to this recommendation.

Transjugular Intrahepatic Portosystemic Shunt(s) (TIPS) (Tab 19)

Presented by: Bibb Allen, Jr., MD, American College of Radiology, and Robert Vogelzang, MD, Society for Cardiovascular and Interventional Radiology Facilitation Committee #1

Four new codes were added to CPT to describe Transjugular Intrahepatic Portosystemic Shunt insertion and revision procedures.

3718X1 (W1)

The committee compared the specialty recommendation of 22.00 RVUs for CPT code 3718X1 and 12.25 RVUs for CPT code 3718X2 to other venous anastomosis procedures, and concluded that these values were too high. In particular, the committee compared code 3718X1 to the following codes:

37140 *Venous anastomosis; portocaval* (RVU = 23.60);
37145 *Venous anastomosis; renoportal* (RVU = 24.61);
37160 *Venous anastomosis; caval-mesenteric* (RVU =21.60); and
38180 *Venous anastomosis; splenorenal, proximal* (RVU=24.61)

By comparing the recently reviewed reference code 34800 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis* (RVU 20.75) to other codes with similar intra-service work to code 3718X1, the committee determined that the intra-service work was similar. However, CPT code 34800 has a 090-day global period versus the 000-day global period for 3718X1. The following visits account for post-operative services:

1x 99231, RVU =0.64;
1x 99232, RVU =1.06
1x 99238, RVU =1.28
1x 99212, RVU =0.43
1x 99213, RVU= 0.65
Total RVU = 4.06

Therefore, approximately 4.00 work RVUs contribute to the total value of the work RUV for code 34800 (RVU = 20.75). The committee considered the post-operative differential and felt that a work RVU of 17.00 approximated the same day procedure work for codes 34800 and 3718X1. In addition, the RUC determined that a value of 17.00 would create a proper rank order.

The RUC recommends a work RVU of 17.00 for 3718X1 (W1).

3718X2 (W2)

The committee reviewed the survey results and determined that the survey respondents felt that W2 was valued at about half of W1. To maintain this relativity, the committee concluded that a value of 8.00 was appropriate, which is approximately half of the recommended value of W1.

The RUC recommends a work RVU of 8.00 for 3718X2 (W2).

Practice Expense

A specialty society consensus panel developed the direct practice expenses. The society used code 34800 as a reference service to determine appropriate direct inputs. No supplies or equipment were required. The RUC decreased the clinical staff time for these services. The RUC recommended staff time of 18 minutes takes into account the non-physician clinician (RN/LPN/MA) time spent (either in the office and/or the hospital) with the patient prior to the procedure, preparing the necessary clinical paperwork, scheduling, post-procedural care instructions, and post-procedure follow-up. The revised direct PE inputs are attached to this recommendation.

Insertion of Permanent Intraperitoneal Catheter for Chemotherapy (Tab 20)

Presented by: Sandra Reed, MD, American College of Obstetricians and Gynecologists

4942X (H1)

CPT Code 4942X *Insertion of Permanent Intraperitoneal Catheter for Chemotherapy* was created to allow physicians to accurately reflect the greater complexity of this procedure as compared to the reference code 49421 *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent*(work RVU= 5.54). In current practice, there are several differences in the two procedures that result in the greater complexity of the new code. The intraservice time for both procedures differs because: 1) 4942X requires 2 incisions while 49421 requires 1 incision, 2) the first incision needs to anchor the port with several sutures and the

second incision is a limited laparotomy, and 3) the second incision makes 4942X a limited open procedure while 49421 is a closed procedure.

The postservice time differs because: 1) 4942X requires the care of 2 incisions while 49421 requires the care of 1 incision, 2) 4942X requires the care and management of a catheter with a port while the catheter in 49421 does not have a port, and 3) 4942X requires the flushing of the port while 49421 does not have a port. The work unit values of other laparotomy codes such as code 47015 (work RVU= 10.49) *Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)* and 58960 *Laparotomy, for staging or restaging of ovarian, tubal or primary peritoneal malignancy (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic lymphadenectomy* (work RVU= 14.65) were reviewed since the proposed code is a limited laparotomy procedure. The RUC believed that in relation to the physician work of the reference code, other laparotomy codes, and the survey results, code 4942X should be valued at 6.65 RVUs.

The RUC recommends a work relative value of 6.65 for CPT code 4942X.

Practice Expense

The RUC agreed to a standard pre-service time of 60 minutes for the 090 global code 4942X. The RUC the assigned the standard pre-service time of 60 minutes, 6 minutes for discharge day charge management, and one office visit. In addition, the code was assigned the approved ob/gyn office visit packet and additional supplies as indicated on the attached recommendation form. There are no in-the-office practice expense inputs.

Omental Flap (Tab 21)

Presented by: Charles Mabry, MD, American College of Surgeons and Keith Brandt, MD, American Society of Plastic Surgeons

CPT code 49905 was revised and CPT code 4990X *Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects)* was created to accurately describe the physician work being performed when:

- 1) A surgeon of one specialty debrides a sternal wound and a second surgeon of another specialty immediately follows the first surgeon and uses a pedicled omental flap for reconstruction;
- 2) The service described by CPT code 49905 was done at a separate operative session as the primary or only procedure.

In both these circumstances, it was impossible to accurately use CPT code 49905, since it is an add-on code. The CPT Editorial Panel revised the terminology of CPT code 49905 without changing the physician work involved.

The RUC recommends no change in the work RVU of CPT code 49905. The RUC recommends a work RVU of 6.55 for code 49905.

The RUC recognized that the work associated with the reconstruction of the chest wall using an omental flap (4990X), is similar to the work associated with 15734 *Muscle, myocutaneous, or fasciocutaneous flap; trunk* (work RVU 17.79). Both flaps are indicated for open and/or infected wounds. Both involve harvesting of a flap on its vascular pedicle, transfer and inseting of the flap to a different site and closure of the donor site. If the muscle flap is being used for sternal wound reconstruction then both share a risk to major structures such as the heart, great vessels, coronary artery bypass grafts and the lungs.

The omental flap, however, typically involves greater work and intensity during the pre and postoperative service periods. The omental flap because of its greater risk and intensity is performed rarely and is usually reserved for patients who: are not candidates for muscle or myocutaneous flap closure; have previously failed flap closure; have unusually large wounds; or have associated illnesses (diabetes, previous irradiation).

The preoperative work for 4990X has a higher intensity because the patient typically has cardiovascular disease, is elderly and has recently undergone a major cardiovascular procedure. The wound is almost always infected and requires one or more debridements. The patient has typically had a prolonged hospital stay, with progressive malnutrition and decreased physical stamina. Management must be coordinated with multiple physicians, including cardiologist, cardiovascular surgeon, infectious disease physician and the primary care physician. Discussions with the patient and family are complicated by the fact that the patient has had a serious postoperative complication and the resultant prolonged hospital stay.

The intraoperative work can vary greatly depending on the status of the abdomen. Multiple previous surgeries will result in greater adhesions of the omentum to the surrounding viscera. The omentum may have been previously debrided forcing the need for greater mobilization of the remaining omentum. Mobilization of the omentum places several intrabdominal structures at risk including several major arteries and veins, the colon, spleen, stomach and liver. The inadequacy of the previous mediastinal debridements and the presence of exposed structures may complicate inseting.

The postoperative work is again complicated by the need to coordinate management with multiple physicians. Wound management must be more vigilant to look for possible recurrent infection. The abdominal harvest results in an abdominal ileus, which further depresses the nutritional status. Care must be coordinated regarding prolonged antibiotic therapy, physical therapy and nutritional replenishment. These patients typically require a stay in an extended care facility and then require visiting nurses for a period after that.

The RUC understood that 4990X requires more work and is more intense than 15734. The current survey data for 4990X compared with Harvard study data for

15734, also indicated that 4990X requires more work and has a higher intensity/complexity profile than 15734.

The RUC recommends the survey median work RVU of 20.00 for CPT code 4990X.

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for CPT code 4990X. Only inputs for the facility setting is provided since these procedures are not performed in the office. Additionally, the staff blend of RN/LPN/MTA is recommended. The RUC agreed that CPT code 4990X required 13 minutes of pre-service clinical labor time, 6 minutes of service period clinical labor time representing discharge day management, and 153 minutes of post-service clinical labor time. For medical supplies the RUC is recommending the standard minimum supply packages for each post-operative office visit as well as post operative incision care supplies. The specific practice expense inputs are attached to these recommendations.

Laparoscopic Urological Procedures (Tab 22)

Presented by: Thomas Cooper, MD, American Urological Association

The creation of four new laproscopic urological procedure codes allows physicians to accurately capture the surgical technique and work effort involved laproscopically compared to an open procedure. These procedures are increasingly being preformed, accepted, and viewed as less invasive alternatives to the open procedures. The RUC reviewed survey data from 50 urologists.

5054X1

The RUC compared code 5054X1 with other ablation codes in general, and with the intra service work intensity of its reference code 50240 *Nephrectomy, partial* (work RVU = 22.00), and it was agreed that the survey results supported the physician work involved. The RUC noted that similar procedures performed using different technologies should have, and do have similar work values.

The RUC recommends a work relative value of 20.00 for CPT code 5054X1.

5054X2

The RUC reviewed and agreed that the survey data collected by the specialty reflected the physician work, time, and intensity of this procedure. The reference code 50545 *Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)* (work RVU = 24.00), with 180 minutes of intra-service physician work, provided additional support for the recommended work value.

The RUC recommends a work relative value of 25.50 for CPT code 5054X2.

5054X3

The RUC agreed that the specialty society should re-survey code 5054X3 for the April 2002 RUC meeting.

5586X1

The RUC reviewed this code in relation to its reference codes 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work value = 28.55), 51595 *Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)* (work value = 37.14), and 50360 *Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy* (work value = 31.53). The RUC reviewed the intra-service time and total time between 5586X1 and the reference codes. The RUC agreed the surveyed median RVU reflected the work associated with the code.

The RUC recommends a relative work value of 30.74 for CPT code 5586X1.

Separately, the RUC recommended that code 5586X1 be flagged for the next 5-year review for its physician time components.

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for CPT codes 5054X1, 5054X2, and 5054X4. Only inputs for the facility setting is provided since these procedures are not performed in the office. The staff blend of RN/LPN/MTA is recommended. The RUC agreed that CPT codes 5054X1, 5054X2, and 5054X4 required 60 minutes of pre-service clinical labor time, 6 minutes of coordination of care clinical labor time, and 6 minutes of discharge day management clinical labor time. In addition, each post-operative visit contains the standard clinical staff time associated with the level of service. For medical supplies the RUC is recommending the standard minimum supply packages for each post-operative office visit as well as a post-operative incision care kit. The specific practice expense inputs are attached to these recommendations.

Measurement of Post-Voiding Residual Urine/Bladder Capacity by

Ultrasound

(Tab 23)

Presented by: Thomas Cooper, MD, American Urological Association

It was agreed by the CPT Editorial Panel that G code G0050 *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound*, be transitioned into CPT with code 5179X tracking number AA1. The use of the new CPT code will be utilized to describe the same activities and functions as previously captured with the temporary G0050 code. In order to capture the full practice expense input costs the RUC requested presentation of the practice expense inputs during the March 2002 PEAC meeting. However, in a subsequent conference call, it was determined that there was a physician work component, in addition to

practice expense. The specialty requests that this issue be considered at the April 2002 RUC meeting.

Male Urinary Incontinence Procedures (Tab 24)

**Presented by: Thomas Cooper, MD, American Urological Association
Facilitation Committee #2**

53440

The original code 53440 stated *Operation for correction of male urinary incontinence* with no mention of the sling or different materials. This old code described placement of a Kaufman prosthesis, placed underneath the urethra to improve incontinence. The Kaufman technology has become obsolete, and the code has recently been used as a male sling operation to differentiate it from the placement of the artificial sphincter.

The RUC reviewed the specialty's reference codes, CPT code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 13.02), and CPT code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU=14.06), in relation to the physician work and time of 53442 and believed they were similar in physician work. It was understood by the RUC that the physician time and intensity for 53442 was similar to a sling operation and to inserting a sphincter. It was also explained that this type of operation is typically more difficult for a male patient than a female patient as in a male patient the surgeon would typically be going through scarred tissue from previous operations. However, CMS requested a further description of the differences between male and female sling operations and removals, which the AUA and the ACOG agreed to provide. During the RUC's discussion one of the post-operative visit office codes was changed from a 99214 to a 99213, reflecting the typical post-operative physician work involved.

The RUC recommends a relative work value of 13.62 for CPT code 53440.

53442

As in code 53440, original code did not adequately reflect the surgical advances and work that had taken place with this procedure, for which it is currently being billed. The code had recently been used to differentiate it from the removal or revision of an artificial sphincter, and needed revision to reflect the surgical technique and physician work involved.

The RUC reviewed the specialty's reference codes, CPT code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 13.02), and CPT code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU=14.06), in relation to the physician time and intensity of 53442 and believed they were similar in physician work. In addition, the RUC understood that the removal or revision of a sling required much more work than the old code, as it was typical to have an infected area, and existing scar tissue under the new procedure rather than the old.

The RUC reviewed codes 57288 and 57287 *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)* (work RVU = 10.71), which are comparable codes for sling operations and sling removals in women. The sling removal work RVU in women is 85% of the sling insertion in women. The RUC recommends a similar ratio for the male codes.

The RUC recommends a relative work value of 11.57 for CPT code 53442.

Practice Expense

The RUC is recommending using the RUC approved practice expense standard packages for CPT codes 53440 and 53442. 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 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/MTA is recommended. The RUC agreed that CPT codes 53440 and 53442 required 60 minutes of pre-service clinical labor time, 6 minutes of service period clinical labor time, and 144 minutes of post-service clinical labor time. 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 as supplies. The specific practice expense inputs are attached to these recommendations.

Neuroendoscopic Surgical Procedures (Tab 25)

Presenter: John A Wilson, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons
Reviewed by Facilitation Committee #3

New codes 6216X1-X6 were developed in order fully to capture the endoscopic work involved with intracranial endoscopy.

6216X6 and 6216X5

The RUC examined the survey results for codes 6216X6 *Neuroendoscopy, intracranial; with excision of pituitary tumor, trans-nasal or trans-sphenoidal approach* and 6216X5 *Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage*. The RUC recommended that the pre-service time for 6216X6 should be lowered from 115 minutes, the original specialty society's recommendation, to 85 minutes. Additionally, the RUC recommended that the day of surgery hospital visit for 6216X6 be changed from 99231, the specialty society's recommendation, to 99232. The RUC believed that the physician work of the reference code 61548 *Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic* (21.53 RVW) and 61510 *Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma* (28.45 RVW) could be used effectively to determine the RVW for these two codes. Therefore, by using the building block method, beginning with the intra-service intensity of these reference codes, the RUC believed the 25th

percentile of the presenter's survey results represented the true relative values for codes 6216X6 and 6216X5. In addition, the RUC understood that 6216X5 was a more intense procedure than 6216X6, as demonstrated in their reference codes and required additional post operative hospital and office care.

The RUC recommends a relative work value for 6216X6 of 22.00 and for 6216X5 of 27.50.

6216X4

Relative to the other codes within the family, code 6216X4 *Neuroendoscopy, intracranial; with retrieval of foreign body* was compared by the RUC across its presented family of codes and specialty procedures. The RUC compared the physician work of 6216X4 to other 090 day global codes such as; code 61150 *Burr hole(s) or trephine; with drainage of brain abscess or cyst* (17.57 RVW), code 54406 *Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis* (12.10 RVW), and 49060 *Drainage of retroperitoneal abscess; open* (15.86 RVW). From these comparisons of physician time and work, and through the building block methodology, the committee had the following recommendation for 6216X4.

The RUC recommends a relative work value for 6216X4 of 15.50

6216X3

The RUC after discussing the survey results for 6216X3 (I3) *Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage* believed that 6216X3 and 6216X5 were similar procedures. The committee wanted to maintain the proper rank order within the family, and understood that 6216X3 takes less time than 6216X5, 61 and 76 minutes respectively, with the same work intensity. By again using the building block approach of using a reference code, 61510 *Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma* (RVW 28.45), as another methodology to justify the relative values, the committee believed that the 25th percentile of the specialty's survey results reflected the physician work involved for 6216X3 (I3).

The RUC made the following relative work value recommendation for 6216X3 of 25.25

6216X2

The RUC then compared code 6216X2 *Neuroendoscopy, intercranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts, including placement, replacement, or removal of ventricular catheter* to its reference code 62200 *Ventriculocisternostomy, third ventricle* (RVW 18.32). Additionally the RUC believed that the physician work involved in this procedure was more than in 6216X4 (recommended RVW 15.50) and less than 6216X3 (recommended RVW 25.25). The RUC discussed the specialty's survey and agreed that the 25th percentile was the correct valuation for 6216X2.

The RUC recommends a relative work value for 6216X2 of 20.00

6216X1

The RUC then examined code 6216X1 *Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure)(Use 6216X1 only in conjunction with codes 61107, 61210, 62220, 62223, 62225, or 62230)* and believed that the specialty survey results were consistent with the procedure, however the pre-service time should be zero as the global period for this code is ZZZ. The RUC believed, as they did while valuing the other codes in the family, that the relative value for this code reflected the 25th percentile of the specialty society's survey results.

The RUC recommends a relative work value for 6216X1 of 3.00

Practice Expense Inputs for 6216X6-6216X1

The RUC reviewed the practice expense inputs for 6216X1-X6 and understood that the standard developed for the 090-day major surgical procedures could not be applied for 6216X2-6216X6 because the pre-service time would be above the PEAC standard of 60 minutes and would require an additional 15 minutes. The codes that include this additional time include: 1.) 6216X2, pre-service time of 85 minutes, 2.) 6216X3, pre-service time of 108 minutes, 3.) 6216X4, pre-service time of 78 minutes, 4.) 6216X5, pre-service time of 90 minutes and 5.) 6216X6, pre-service time of 115 minutes. The RUC recommends no inputs in the office setting. Additionally, **the RUC recommends all of the practice expense inputs presented by the specialty society, as attached to this recommendation.**

Percutaneous Lysis of Epidural Adhesions (Tab 26)

Presenters: Karl E. Becker, MD, American Society of Anesthesiologists; Laxmaiah Manchikanti, MD, American Academy of Pain Medicine, Samuel Hassenbusch, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons

Reviewed by Facilitation Committee #4

Doctor Gerety presented the facilitation committee report to the RUC. She stated that the specialty had agreed to re-survey code 6226X *Percutaneous lysis of epidural adhesions using solution injection (eg, ~~hypertonic saline~~, enzyme) or mechanical means (eg, spring wound catheter) including radiologic localization (includes contrast when administered), 1 day* while giving consideration to the reference service list which should list the global periods. Additionally, the specialty should discuss the use of a 010 global rather than and 000 day global with CMS. Doctor Gerety concluded by stating that the specialty society must re-survey these codes to get more interpretable values for the RUC and have a pre-facilitation meeting prior to the April meeting.

Nerve Injection/Block and Daily Management of Continuous Drug Administration (Tab 27)

Presented by: Karl E. Becker, American Society of Anesthesiologists; Norm Cohen MD and Samuel Hassenbusch

Codes 64415, 6441X, 6444X1, 6444X2, 64445, 6444X3 have been sent back to the American Society of Anesthesiologists to develop new recommendations. The RUC was particularly concerned with work neutrality issues within the family. An ad hoc facilitation meeting prior to their presentation at the April RUC meeting has been requested by the specialty society.

Ophthalmic Diagnostic Endoscopy (Tab 28)

No specialty society presentation

The American Academy of Ophthalmology has withdrawn their recommendation for code 6999X - *Use of Ophthalmic Endoscope* from the agenda. They will be re-presenting at the April RUC meeting.

Bone Density Studies (Tab 29)

Presented by: Bibb Allen, MD, American College of Radiology

As part of the overall project to move physician services described by HCPCS Level II G codes into CPT, the CPT Editorial Panel revised CPT code 76070 *Computed tomography bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)* (work RVU = 0.25) and created code 7607X1 *Computed tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral (eg, radius, wrist, heel))* to better differentiate these services. The RUC considered survey data from radiology and determined that the survey median of 0.22 was appropriate for the new code 7607X1. The total time of twenty minutes is comparable to the total time for reference service 76076 *Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work RVU = 0.22). This is also the current work value assigned by CMS to G code G0132 *Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g. radius, wrist, heel)* (work RVU = 0.22).

The RUC, therefore, recommends a work RVU of 0.22 for CPT code 7607X1.

The RUC also reviewed the direct practice expense inputs for 7607X1 and made one adjustment to the specialty society recommendation by eliminating the staff time to escort the patient back to the waiting area. The revised inputs are attached to this recommendation. The RUC recommends no direct practice expense inputs when the service is performed in a facility setting.

Percutaneous Cardiac Procedures (Tab 30)

Presenters: Michael Freed, MD, and James Maloney, MD, American College of Cardiology

The CPT Editorial Panel created two codes to describe percutaneous transcatheter closure of cardiac defects, 9356X1 *Percutaneous transcatheter closure of interatrial communication (ie, fontan fenestration, atrial septal defect) with implant* and 9356X2 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant*. The RUC reviewed survey data from more than 30 pediatric cardiologists and compared the survey data to the current CPT codes that describe these services performed via open technique.

The RUC compared CPT code 33641 *Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch* (work RVU = 21.39) with new CPT code 9356X1 and determined that the pre, intra, and immediate post-service time is essentially the same for both services. Only Harvard time was available for this reference service. The RUC determined that an increment of 3.39 was appropriate to capture the post day of procedure work included in the open code, therefore, the survey's 25th percentile of 18.00 appeared reasonable.

The RUC recommends a work RVU of 18.00 for CPT code 9356X1.

The RUC compared CPT code 33681 *Closure of ventricular septal defect, with or without patch* (work RVU = 30.61) with new CPT code 9356X2 and determined that the pre and immediate post-service time is essentially the same for both services. The new percutaneous procedure requires approximately 30 minutes additional intra-service time, however the work value for this service does not include the extensive post day of procedure time included in the open procedure code. 99681 includes six 99231, one discharge day management, two 99213 and one 99214 office visits. The RUC computed a work relative value for 9356X2 of 24.43 by backing out the post-operative visits from 33681, while allowing for additional intra-service time for the new procedure. The work RVU recommendation of 24.43 is slightly less than the 25th percentile of the survey data from pediatric cardiology. The RUC agreed that this maintained an appropriate relationship between 9356X1 and 9356X2.

The RUC recommends a work RVU of 24.43 for CPT code 9356X2.

The RUC did note that the specialty should continue to review the appropriateness of a 000 day global for these services and consider reviewing these codes again in the future, if a different global period (ie, 010 or 090) appear more appropriate.

The RUC recommended that the practice expense inputs (pre and post clinical staff time) be modified to be consistent with the cardiac catheterization direct inputs, as approved by the PEAC at their January 2002 meeting. The revised recommendations are attached to this recommendation. This service is not performed in the office setting.

Refilling of Implantable Infusion Pump (A)

Presenters: Samuel Hassenbusch, MD, American Association of Neurological Surgeons and Congress of Neurological Surgeons; Scott Fishman, MD, American Academy of Pain Medicine; Karl Becker, MD, American Society of Anesthesiologists

Reviewed by: Pre-Facilitation Committee 1

At the request of the specialty, this issue was referred to pre-facilitation prior to full RUC review. During the pre-facilitation committee meeting, CMS staff raised concerns regarding the interpretation of the code and the physician work involved. The specialty requested to defer discussion of this issue until the April RUC meeting until the interpretation issues should be further resolved with the CMS.

Mandated Physician On-Call (Tab B)

No specialty society presentation

The RUC discussed two new CPT codes created to describe hospital mandated on-call service. During the level of interest process, several specialty societies expressed an interest in developing a recommendation, however, after reviewing the codes these specialties determined that it would not be possible to report these services to any payor and questioned the validity of determining relative values. The RUC agreed that this is a complex issue that should be further explored. The RUC referred this issue to the Research Subcommittee for further discussion.

Pediatric Intensive Care/Neonatal Intensive Care Codes (Tab C)

Presented By: Steve Krug, MD, American Academy of Pediatrics

Reviewed by Facilitation Committee #4

The CPT Editorial Panel created new codes to describe pediatric critical care services. In addition, the Panel revised the existing neonatal critical care services to better define these services. The RUC reviewed survey data from more than 50 neonatologists.

The RUC reviewed the survey time data for the initial pediatric intensive care (PICU) services and determined that the total time of 240 minutes were comparable to the total time for four hours of critical care services, 99291 (work RVU = 4.00). The RUC, therefore, determined that the 25th percentile of the survey was appropriate for 99293X1 *Initial pediatric critical care, 31 days up to 2 years of age, per day, for the evaluation and management of a critically ill infant or young child.*

The RUC recommends a work relative value of 16.00 for 99293X1.

The RUC reviewed the survey time data for the subsequent PICU services and determined that the total time of 140 minutes were comparable to two hours of

critical care services, 99291 (work RVU = 4.00). Therefore, the RUC agreed that the 25th percentile of the survey was appropriate for 99294X1 *Subsequent pediatric critical care, 31 days up to 2 years of age, per day, for the evaluation and management of a critically ill infant or young child.*

The RUC recommends a work relative value of 8.00 for 99294X1.

The RUC discussed the coding revisions made to CPT codes 99295, 99296, and 99297 and determined that additional data needed to be collected prior to the April RUC meeting, in order to appropriately value these services. These codes were referred to a facilitation committee (Doctors Gage (Chair), Gerety, Hannenberg, Smith, Taubman, Pfeifer, and Traugott). The facilitation committee requested that:

- The specialty society re-survey 99295 and 99296 prior to the April RUC meeting. It became clear that the survey respondents may have been confused regarding the inclusion of procedural time (ie, the respondents may have only included face-to-face critical care time in their estimates).
- The specialty society should ask the survey respondents to list the procedures typically performed, along with identification of critical care and other time spent per date of service.
- The specialty society should request an e-mail review of this new survey by the facilitation committee prior to conducting the survey. The facilitation committee will pre-facilitate this issue prior to the April RUC meeting.

The RUC reviewed CPT codes 99298 *Subsequent ~~neonatal~~-intensive care, per day, for the evaluation and management of the recovering very low birthweight infant (present body weight less than 1500 grams)* and 99299X1 *Subsequent intensive care, per day, for the evaluation and management of the recovering low birthweight infant (present body weight of 1500-2500 grams).* The RUC determined that the changes made to 99298 were editorial in nature and would not reflect a change in work. The RUC reviewed survey data from 55 neonatologists and agreed that the 25th percentile of 2.50 was appropriate.

The RUC recommends a work value of 2.75 for 99298 and 2.50 for 99299X1.

These services are all performed in a facility. The RUC recommends no direct practice expense inputs related to these services.

X. Practice Expense Advisory Committee Report (Tab D)

Doctor Moran presented the results of the August, 2001 PEAC meeting, which included PEAC refinements to 187 codes. Doctor Moran informed the RUC that the PEAC has identified large numbers of codes for refinement by requesting specialty societies to identify families of codes associated with their 10 highest

frequency codes as determined by Medicare frequency data. Specialties were also allowed to supplement the list with codes that were a priority for the specialty society. The codes identified through this process will be refined during the 2002 PEAC meetings. The PEAC continues to develop standardized packages of direct inputs to simplify refinement and create consistent standards.

The PEAC has forwarded several issues to the RUC such as visit data missing from Harvard physician time files and also a request to examine the definition of ZZZ codes. A RUC member asked how a specialty society could fix rank order anomalies in practice expense relative values. Doctor Moran explained that specialties have always been free to bring any codes forward to fix anomalies, as this was one of the original reasons for creating the PEAC. The PEAC has also focused on refining families of codes so as to prevent the creation of anomalies of codes.

The RUC approved the PEAC report and the direct practice expense input recommendations. The approved report is attached to these minutes.

XI. Multi-Specialty Points of Comparison Workgroup Report (Tab E)

Doctor Charles Koopmann presented the report from the Multi-Specialty Points of Comparison (MPC) Workgroup. At this meeting, the workgroup reviewed a list of 286 CPT codes submitted by specialty societies for inclusion on the RUC's new MPC list. The workgroup determined that these codes should be categorized in terms of their qualifications in meeting the list of pre-determined criteria.

The RUC recommends that each code on a single MPC list be designated with an indicator as follows:

A = The code meets all of the absolute criteria.

B = The code does not have RUC time data available, however, the code is performed by several specialties and is well understood by many physicians.

C = The code does not have RUC time data available, however the specialty society would like the code included as a reference point.

A member of the RUC emphasized that the list was currently a work in progress. The RUC agreed that the specialty societies should have another opportunity to review the MPC list prior to the presentation of the list to the RUC in April.

The approved report of the Multi-Specialty Points of Comparison Workgroup is attached to these minutes.

XII. RUC Health Care Professionals Advisory Committee (HCPAC) Review Board Report (Tab F)

Don Williamson, OD presented the report of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board Report. Dr. Williamson explained that the RUC HCPAC Review Board reviewed relative value recommendations related to Gait and Motion Studies. The HCPAC also addressed survey instrument issues in regard to psychological and neuropsychological assessment services (CPT codes 96100 - 96117).

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

XIII. Practice Expense Subcommittee Report (Tab G)

Practice Expense Subcommittee Report

The Practice Expense Subcommittee met January 31, 2002 to discuss issues relating to physician time, and CMS's zero work pool methodology.

Physician Time Ground Rules

Doctor Robert E. Florin, MD presented to the subcommittee that a set of ground rules on physician time be used to validate and standardize this data element. Doctor Florin and staff agreed to discuss the computations of physician time.

Post Operative Visit Data and the Practice Expense Advisory Committee (PEAC)

During the August 2001 PEAC meeting, several perceived inconsistencies in the number and level of E/M services in the global period for certain CPT codes were identified and brought to the attention of the Practice Expense Subcommittee for further review. During this PEAC meeting, AMA staff identified where the inconsistencies exist within CMS's post operative visit data, each of these codes indicate a total physician time, and nothing else. In order to resolve any future inconsistencies in the RUC database post operative visit data and to assist the PEAC in its practice expense refinement, the RUC approved the following recommendation:

The RUC directed that AMA staff send approximately 280 codes for which there is no CMS post operative visit data to the specialty societies to ask them to address the following issues:

1. Do you agree that the total physician time is valid?

If the answer to number 1 above is yes, the RUC asks the specialty societies to allocate the total physician time into the various time components of pre-service, intra-service, and immediate post service time periods, and include the number and level of post operative hospital and office visits.

If the answer to number 1 is no, the RUC would provide the specialty society the opportunity to survey and bring the results before the Practice Expense

Subcommittee and the RUC for approval. The survey would strictly be on physician time and would have no bearing on physician work.

During the August 2001 PEAC meeting, The American Academy of Orthopedic Surgeons and the PEAC identified a perceived inconsistency in a family of codes and had requested a crosswalk of post operative discharge day management time for four codes. The Practice Expense Subcommittee reviewed the family of codes and the request during its September 19th conference call, and agreed not to recommend the crosswalk at that time, but to refer the issue to the full RUC for review at the February 2002 RUC meeting. During this subcommittee meeting, the subcommittee again discussed the reallocation of existing post operative discharge day management time, and the RUC discussed and approved the following recommendation:

- A. The RUC agrees that there can be one or one-half of a discharge day management code for any surgical procedure code when performed in the facility setting.**
 - 1) The RUC should reallocate existing post service time to all outpatient surgical procedure codes (typically performed in an ASC or hospital outpatient department) so that one-half of a discharge day management code time element exists in the RUC physician time database.**
 - 2) The RUC should reallocate existing post service time to all inpatient surgical procedure codes so that a full discharge day management code time element exists in the RUC physician time database.**

Destruction by Neurological Agent Family – Response from Specialty Society

In the August 2001 PEAC meeting, a perceived inconsistency in the physician time database was identified by the North American Spine Society (NASS). The RUC approved the following recommendations concerning NASS's request for changes in the post operative visit data in the RUC database:

- 1. The post operative visits data contained in the RUC database for recently RUC surveyed codes, 64614 and 64626, should not be changed.**
- 2. NASS should investigate, with no objection from the RUC, changing the global periods of codes 62280, 62281, 62282, 64612, 64613, and 64614.**

Lewin Report on Practice Expense Methodology – Zero Work Pool

On June 5, 2001, Lewin issued its analysis entitled "The Resource-Based Practice Expense Methodology: An Analysis of Selected Topics". The Practice Expense Subcommittee had a particular interest in Lewin's discussion of the zero work pool, as CMS's method of establishing practice expense RVUs for codes without physician work may change due to this analysis. The subcommittee discussed Lewin's conclusions and recommendations to CMS and had some concerns about the possibility of CMS using physician work RVUs as a substitute for patient care hours. The subcommittee believed that linking physician work to practice expense would cause an inconsistency with the resource-based approach, as

required by statute. The RUC approved the following recommendation: **The RUC expresses concern to CMS regarding recommendation VII of the Lewin report (pages 42-43).**

The subcommittee also discussed the process by which new codes with zero physician work are assigned practice expense relative values. The RUC approved the following recommendation: **When specialty societies present a CPT code with a zero physician work value, the cover letter should state whether the particular code and its code family for which it is contained, should be in or out of the zero work pool. If the zero work pool is appropriate, the specialty should identify what crosswalk is appropriate, in addition to the usual practice expense inputs.**

XIV. Research Subcommittee Report (Tab H)

Doctor James Hayes presented the Research Subcommittee report.

Critical Care

The RUC initially agreed with the subcommittee recommendation to reaffirm the RUC position that there is no evidence that a change in national Medicare payment policy is warranted due to the RUC inclusion of critical care services in the global package. However, a RUC member felt that the recommendation did not go far enough and that it may lead to new payment policies that private payers might implement to reduce payments to surgeons, who practice in a hospital with closed critical care units. Other RUC members felt that the RUC should take a stronger stance on the issue and petition CMS to instruct its carriers that denying payment based on the inclusion of critical care in the global period was inappropriate. The RUC was in agreement that the RUC methodology of inclusion of critical care in the global package should not lead to inappropriate payment policies that could ultimately discourage quality care and the team approach of providing critical care services.

It was also pointed out that reducing payments to surgeons just because critical care services are included in the global package is inconsistent with the RUC methodology. This is because the work RVU for the surgical codes is not developed through an additive building block approach where the full value for critical care services is included in the final RVU.

The RUC referred the motion back to the research subcommittee to further examine the issue of inclusion of critical care services in the global period with the goal of developing a position statement that explains the policies of the RUC on this issue. This position statement could then be shared with CMS and help CMS and their carriers better interpret the RUC policies on this issue.

IWPUT

A number of RUC members disagreed with the Subcommittee recommendation to encourage the use of IWPUT. A RUC member pointed out that a CMS sponsored study rejected the use of Rasch analysis for developing work RVUs. Another RUC member stated that IWPUT and Rasch analysis are not statistically proven methodologies and should not be encouraged. Others reminded the RUC that IWPUT and Rasch analysis have been used in the past as adjunctive measures and the Subcommittee is not recommending changing what has become the current practice for many specialties. Many specialties currently use IWPUT calculations in support of the survey data. The Subcommittee also stated in its report that it will review the various IWPUT calculations and recommend a standard, however, the subcommittee felt that such a measurement technique should be encouraged to supplement the survey, not to replace the survey.

The RUC voted to refer this issue back to the Research Subcommittee. The Subcommittee should first agree on a single IWPUT formula and methodology for including IWPUT calculations in the Summary of Recommendation form.

ZZZ global period definition

The RUC was in favor of changing the definition of the ZZZ codes, however, the RUC felt that it did not have the authority to change the definition and rather such a change needed to come from CMS. **The RUC will request CPT and CMS to change the definition of ZZZ codes to delete the word “intra-service.” The new definition would be: ZZZ codes are reported in addition to a primary procedure and only the additional work to perform this service is included in the work RVU.**

Other Issues

The RUC approves ACOG’s proposal for surveying the incremental work involved in the complex hysterectomy codes.

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

XV. Anesthesia Facilitation Committee Report (Tab I)

Doctor Mayer presented the anesthesia workgroup report to the RUC. Doctor Mayer explained that the workgroup made progress on one of the outstanding issues relating to the five-year review. This pertained to establishing a value for the induction period procedure associated with code 00142 *Anesthesia for procedure on eye; lens surgery*. After reviewing literature on this topic and refining the methodology for valuing the induction period procedure the workgroup adjusted the induction period procedure work value calculations by multiplying the 8 minutes associated with this part of the procedure by the percentage of times each type of anesthesia is provided and then multiplying by an IWPUT. The calculations are as follows:

	Time	%	IWPUT	RVU
Retrobulbar block		8	.28	.067 = 0.1501
general anesthesia	.	8	.02	.067 = 0.0107
Deep Sedation		8	.56	.057 = 0.2554

Total work RVU for induction period procedure equals .4162

The second remaining issue involves the validation of the post induction quintiles and the workgroup has proposed a process for this validation. This will involve distributing information of the codes selected by ASA and then convening a meeting of RUC members and advisors to review the distribution of post induction time among the five quintiles. The workgroup plans on completing its work relating to the five year review at the April meeting so the any recommendations can be sent to CMS by the end of May.

A RUC member commented that the review of anesthesia services is a very complex issue and that any future refinement could only occur if the anesthesia values were on the same scale as the RBRVS. Doctor Hoehn reminded the RUC that the workgroup’s long-term goal is to examine the possibility of placing ASA codes on the same scale as other physician services.

The Anesthesia Facilitation Committee report was approved and is attached to these minutes.

XVI. Services Reported with Multiple Codes Workgroup Report (Tab J)

Doctor Barbara Levy reported that the Valuing Services Reported with Multiple Codes Workgroup met on Thursday, January 31 to hear presentations from the Society of Cardiovascular and Interventional Radiology and the American College of Cardiology regarding their component coding systems. Doctor Levy explained that the workgroup will be developing guidelines for presentation of relative values for services that are typically reported with multiple codes. The workgroup has also requested that CMS compile information on groups of services that are most typically provided and reported on the same data.

The RUC approved report from the workgroup is appended to these minutes.

XVI. Administrative Subcommittee (Tab K)

Doctor William Gee presented the Administrative Subcommittee report. The RUC approved the following recommendations from the Administrative Subcommittee:

- **The RUC unanimously approved the use of Fax Back Ballots to resolve issues that do not require discussion of work RVUs.**

- **The RUC also approved that subspecialties deemed eligible for the Internal Medicine or other rotating seats, may choose individuals that represent the interest of the subspecialty group and that a board certification in that particular specialty is not a requirement.**
- **The RUC agreed that codes, in which there is no specialty interest in preparing a presentation to the RUC, should be presented to CMS as codes that do not have recommendations from the RUC.** There was some concern from RUC members that codes that were not presented by a specialty society would be assigned values by CMS that were not appropriate. Representatives from CMS assured RUC members that in the case that a CPT code was not presented by a specialty society, CMS would make every effort to contact those specialty societies affected by the coding change, in writing.
- **Specialty Societies should decide whether industry representatives or other non-RUC participants assist in their presentation. Guests of the specialty society or the chair should be required to wear a special color nametag to indicate that the person is a guest.**
- **The Statement of Compliance language should be renewed unchanged. RUC members will be required to sign these forms annually. The Conflict of Interest Policy will remain the same. Financial Disclosure forms will no longer be included in the agenda book unless financial disclosure is necessary, however, these forms should be submitted to the AMA staff to keep on file.**
- **The RUC accepted the Committee's recommendation to shorten the biographical information to a sketch of their CV. Staff will draft a template that will highlight contact information and background experiences.**

Finally, the RUC agreed that AMA Staff did a wonderful job planning the previous 10-year Anniversary dinner despite the events of September 11th. The RUC was in agreement with the Committee that the staff should plan a formal Black-tie event for the September 2002 meeting.

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

XVIII. Conscious Sedation Workgroup Report (Tab L)

Doctor William Gee reported to the RUC that the Conscious Sedation Workgroup convened on February 2 to reaffirm its recommendation to the RUC that the

general approach should be to retain the conscious sedation as bundled into the procedure code only where it is an inherent part of the service.

The RUC recommends the following:

- 1. The general approach to the conscious sedation issue should be to retain the conscious sedation as bundled into the procedure code only where it is an inherent part of the service.**
- 2. Separate reporting and payment of conscious sedation codes 99141 and 99142 should be allowed when conscious sedation is not inherently included as a component of the physician work of the procedure code.**

The workgroup also suggested a process to ask specialty societies to identify which codes inherently include conscious sedation. The workgroup will review the results of this identification process on or before the April RUC meeting.

The RUC recommends that an identification process initiate to determine which codes inherently include conscious sedation and which codes may sometimes require conscious sedation.

Doctor Gee reported that the issues related to relative value evaluation and changes to CPT descriptors will be discussed after the above identification process is completed.

The RUC approved report of the Conscious Sedation Workgroup is attached to these minutes.

XIX. Other Issues

The RUC Meeting concluded on Sunday, February 3, 2002, at 10:30 am.

**AMA/Specialty RVS Update Committee
Practice Expense Advisory Committee**

August 23-25, 2001

Chicago, Illinois

Bill Moran, MD (Chair)	Alex G. Little, MD
James Anthony, MD	James Metcalf, MD
Deborah Bash, MD*	Peter McCreight, MD*
Stephen Bauer, MD	Tye Ouzounian, MD
James Borgstede, MD*	Ronald Shellow, MD
Katherine Bradley, PhD, RN	Dighton C. Packard, MD
Ann C. Cea, MD, FACR	Julia Pillsbury, DO
Manuel D. Cerqueira, MD	Greg Przybylski, MD*
Neal Cohen, MD	James Regan, MD
Thomas A. Felger, MD	Joseph Schwartz, MD*
Blair Filler, MD	Anthony Senagore, MD
Mary Foto, OTR	Daniel Mark Siegel, MD, MS
David Hoak*	Fredrica Smith, MD*
Ronald L. Kaufman, MD, MBA	Robert Stomel, DO
Charles Koopman, MD*	J. Craig Strafford, MD
Gregory Kwasny, MD	Neal Templeton, MD

*Alternate PEAC Member

Pre-Service Standards for 90 day Global Period Procedures

During the February 2001 PEAC meeting, the PEAC approved 60 minutes in the facility setting and 35 minutes in the office setting as the standard pre-service times for codes with global periods of 90 days. At the same meeting, the PEAC also approved of a methodology for calculating the clinical staff time associated with the post service office visits. During the March 2001 PEAC meeting, the PEAC recommended the pre-service standard clinical staff time of 60 minutes and the post-service office visit time calculation methodology 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. In addition, the original workgroup examining this issue, under the direction of Doctor Templeton, was charged with further defining the standard and establishing guidelines for deviating from the 60 minute standard. The workgroup presented their findings during the August 2001 meeting (the report is attached). The workgroup reported that they reconfirmed that the standard times were averages based on various types of procedures and accounted for the variability in pre-service time among codes. The workgroup reported that they had discussed and reviewed various methods for determining outliers, and alternatives to the single 60 minute standard, but were unable to develop a specific methodology for either. The PEAC agreed with the workgroup's conclusion and recommendations and approved the following recommendation from the workgroup:

Approved at the February 1 – 3, 2002 RUC Meeting.

The PEAC reaffirmed its acceptance of the pre-service time standards (60 and 35 minutes) and that these standards reflect an average time that covers the vast majority of 90 day global procedures. The consensus of the PEAC was that there may be codes with pre-service times greater than the standard but the PEAC was unable to develop a methodology for identifying such outliers. The PEAC recommends that if a specialty society believes that additional time is warranted for particular codes, the society should use the PEAC template and justify the additional time on a line by line basis by examining each staff activity and include a comparison to the approved standard times.

The PEAC had agreed previously that the 60 minute standard would be applied to all 90 day global period codes after a one year grace period, during which time outliers below or above the standard could be refined by specialties. The one year grace period originally had been scheduled to begin in March 2001 to be then implemented in the year 2003. PEAC members during the August 2001 meeting believed that this was not enough time for specialties to refine their codes, and the PEAC recommended the one year grace period would begin in August 2001, for implementation in the year 2004. The PEAC recommends the following:

Specialty societies have until the September, 2002 PEAC meeting to identify and bring forward any 90 day global codes that may have pre-service times that deviate from the standards.

Pre-Service Standard for 0 and 10 day global periods

The PEAC assigned a workgroup to examine pre-service time standards for 0 and 10 day global codes. The workgroup examined the pre-service time for a number of 0 and 10 day global codes and reported that there was a high degree of variability among the codes, and that it was not possible to develop a standard time applicable across the board for all of these codes. However, the workgroup believed that individual specialties should still refine the direct inputs for codes with 0 and 10 day global periods. The workgroup agreed that a pre-service time may be appropriate for many of these codes, but did not agree with the concept of a standard value. Instead, the workgroup recommended the PEAC review each code on a line by line basis and make a recommendation based on the rationale offered by the specialty society. In order to complete refinement of the 0 and 10 day global codes, the workgroup felt that specialties should have one year to bring their codes forward. After a year, the PEAC should submit a recommendation of zero minutes of pre-service time for all 0 and 10 day codes that have not been refined by the PEAC. The PEAC discussed that since the agendas for the 2002 PEAC meetings are quite full, the PEAC may wish to reexamine the deadline again in the future, if there is not enough room on the agendas for the specialties to bring forward their 0 and 10 day global period codes. The PEAC approved the following conclusion and recommendation from the workgroup:

The PEAC recommends that by the September 2002 PEAC meeting, those codes with global periods of 0 and 10 days will receive a PEAC recommendation of zero

minutes of pre-service time unless a specialty recommends otherwise and is able to provide sufficient data to the PEAC to justify the recommended times.

In addition, the PEAC examined the existing standard inputs for in-office procedures and reaffirmed that the existing standards are valid. The PEAC determined that additional standards could not be developed at this time, and that several staff activities such as assisting the physician and monitoring the patient following the procedure were considered too variable to standardize. Instead, the PEAC recommended that the standards already approved by the PEAC be used when possible. Also, if a specialty crosswalks time from the existing E/M standard time to non E/M codes, the time for each activity needs to be fully explained and justified on a line by line basis. The PEAC reconfirmed its support for the existing PEAC standards for the following clinical activities:

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

Coordination of Care and Chaperone (Escort) Clinical Labor Time

The PEAC assigned a workgroup at the February 2001 meeting to discuss two issues; (1) coordination of care clinical staff services in support of hospitalized patients, and (2) chaperone (escort) clinical staff time during post-operative E/M visits for 10 and 90-day global codes.

Coordination of Care Time

The workgroup reported that specific procedures or services may require the assistance of office-based clinical staff, particularly to provide clinical information to hospital staff and family members during the patient's hospitalization. The workgroup reported that it was difficult to standardize coordination of care time, but that some general definitions could be developed. The workgroup presented the following recommendation to the PEAC:

- A. Based on the complexity of the clinical situation, additional coordination of care provided during the hospitalization can be defined based on the level of complexity, as follows:
 1. Basic - 0 minutes
 2. Moderately Complex - 3 minutes
 3. Complex - 6 minutes

- B. Since time for coordination of care is already included in the codes for management on the day of discharge, the workgroup recommends that each specialty society provide the PEAC with specific justification for the level chosen for specific codes or families of codes.

The workgroup developed the 3-minute intervals based on the typical phone call time, believing that for moderately complex patients, the equivalent of 1 phone call would be required, and for complex patients the equivalent of 2 phone calls would be required.

The PEAC had several concerns with the workgroup's recommendation. Specifically, some PEAC members believed that most or all of the coordination of care work would usually be performed by the physician if at all, and would rarely be performed by office clinical labor staff. Others believed the coordination of care time was too low. In addition, the PEAC felt that this type of care would occur occasionally and not typically, and would depend on the procedure and specialty. PEAC members agreed that different specialties and services require different levels of care, and the workgroup had attempted to come up with a standard to be applied in all cases. The PEAC concluded that this was not possible due to the variability in the levels of coordination of care. The PEAC agreed on the following recommendation:

The PEAC agreed that when specialty societies bring codes forward for refinement with an additional level coordination of care, the additional coordination of care level time (moderately complex – 3 minutes or complex – 6 minutes) would be voted on by the PEAC, based on the complexity of the clinical situation.

In addition, CMS officials stated they would provide a list of codes that currently have significant time allocated to coordination of care. The list of codes would then be reviewed by the PEAC.

Another motion relating to clinical staff time associated with hospital based care was discussed. A motion recommending that the subsequent hospital care codes 99231, 99232, and 99233 should have zero practice expense inputs assigned. The PEAC discussed this motion and there was a clarification that specialties would be able to identify exceptions to this rule, but for most codes it was envisioned that there would be no inputs assigned to these codes. After much discussion, this motion was not passed by the PEAC.

Chaperone (Escort) Clinical Labor Time

The PEAC workgroup had been asked to examine the extent to which chaperones were needed to assist the physician during selected evaluation and management services. The workgroup was also asked to determine if, the time could be standardized across codes, when chaperones were required.

The workgroup reported to the PEAC that chaperones are occasionally needed as part of evaluation and management services in the post operative period for 10 and 90 day global codes, but that the variability in the use of chaperones made it impossible to assign a

single value for the chaperone activities. Members of the workgroup agreed that the time required varied considerably depending on the services for which the chaperone is required, and recommended to the PEAC the following three categories of chaperone related clinical staff time:

1. Examination of the genitalia 7 minutes
2. Examination of the rectum 2 minutes
3. Examination of the breast 4 minutes

These standard times would be applied regardless of gender, non-additively, and in addition to the time for assisting the physician during the post-operative E/M visit.

PEAC members expressed a variety of concerns with the workgroup's recommendation. Specifically PEAC members believed the time was either too high or that the time was already captured in the assist physician time category for most procedures. Therefore, approving additional time would lead to double counting of time. A number of PEAC members questioned the need for additional chaperone time since the current E/M time already includes time to assist the physician. The PEAC did not accept the workgroup's recommendation, however did make the following recommendation:

The PEAC did not exclude the possibility of chaperone clinical labor time, but believed it should be considered on a code by code basis when brought to the PEAC.

Neurosurgical Pre-Service Clinical Staff Time

At the January 2001 PEAC meeting, a standard input package of 60 minutes for pre-clinical staff time for all 90 day global procedures was adopted by the PEAC. During the August 2001 PEAC meeting, representatives from the American Association of Neurological Surgeons (AANS), the Congress of Neurological Surgeons (CNS), and the North American Spine Society (NASS), presented survey results, and described to the PEAC that neurosurgery and spine surgery were two areas of medicine where the pre-service activity times are higher than the recommended package time of 60 minutes. The joint Coding & Reimbursement Committee of the AANS-CNS analyzed all Neurosurgical codes and decided that Neurosurgical procedures should be categorized into seven families for purposes of this activity. A survey was developed and a variety of practice types (private, academic and small and medium groups) from across the country were asked to assist in helping to determine the times for services performed by their office clinical staff for pre-service activities. Out of 25 Neurosurgical groups surveyed, 23 responses were received from all geographical areas. NASS independently further divided the spine codes into 15 families and proceeded with a similar survey receiving 57 responses. These 15 families were then combined into three spinal families and reported with the Neurosurgical survey results. A consensus panel then met and analyzed and compiled the data.

The consensus panel believed that when Neurosurgery and spinal surgery are considered separately, 70 minutes of pre-service time is a more accurate median value. This was due

to the inherent surgical complexities of procedures, whereas some of these codes will fall below the median 70 minutes, (50 minutes) and others require greater time (90 minutes). The specialties presented a tiered system of pre-service clinical staff time of 50, 70 and 90 minutes, for 37 families of codes.

The PEAC discussed at great length the pre-service time for each of the families of codes presented by the specialties. The PEAC did not agree with the presenting specialties presenting pre-service clinical staff times for some codes that were predominately performed by other specialties. The PEAC then agreed to extract the following families of codes from the discussion since other specialties provided the codes and were not involved in the development of the recommendation:

Neuroplasty (Exploration, Neurolysis or Nerve Decompression)

64702	64713	64719
64704	64714	64721
64708	64716	64722
64712	64718	64726

Transection or Avulsion

64732	64742	64760
64734	64744	64761
64736	64746	64763
64738	64752	64766
64740	64755	64771

Excision, Somatic Nerves

64772	64776	64784	64788	64792
64774	64782	64786	64790	64795

Sympathetic Nerves

64802	64804	64809	64818	64820
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Neurorrhaphy

64831	64835	64840	64857	64861	64864	64866	64870
64834	64836	64856	64858	64862	64865	64868	

Neurorrhaphy with Nerve Graft

64885	64891	64895	64898	64905
64886	64892	64896	64901	64907
64890	64893	64897	64902	

The PEAC discussed the remaining codes and had significant concerns over whether any time over the 60 minute standard was justified, and didn't agree with a tiered system. Many PEAC members reiterated that the 60 minute standard was the average time based on various types of procedures and accounted for the variability in pre-service time

among codes. In addition, the PEAC believed the clinical activities described by the presenters could be applied to most other codes, and therefore didn't warrant additional time. With this in mind, the PEAC rejected the presenter's tiered system of 50, 70, and 90 minutes.

The PEAC however, believed that some of the Neurosurgical codes presented did require additional clinical staff time. Specifically, the PEAC agreed with the presenters that based on the complexity of the procedures in some of the families of codes, additional clinical staff time was required for; pre service diagnostic and referral form completion, scheduling space and equipment in the facility, and follow-up phone calls and prescriptions. In addition, the PEAC understood that many of these neurosurgical procedures required extensive pre-service education, consent, and patient preparation. Therefore, for 19 families, the PEAC approved an additional 15 minutes since it was determined that these groups of codes were considered procedures requiring additional clinical staff time:

The Neurosurgical codes recommended with a pre-service time of 50 and 70 minutes were changed to the 60-minute standard. The Neurosurgical codes recommended with a pre-service time of 90 minutes were recommended at 75 minutes.

The codes for which the above recommendation refers to are attached to the minutes.

Codes Extracted from ZZZ, 000, XXX Refinement Lists

During the March 2001 meeting the PEAC approved refining the facility based inputs for over 900 codes. Most of the codes did not have direct inputs assigned, and the PEAC confirmed this refinement for all but 26 codes that were extracted. The RUC approved the PEAC recommendation for zero inputs in the facility setting for ZZZ, and no supplies or equipment for 000, and XXX codes, and sent the recommendation to CMS. The following 26 codes were extracted from the lists, and the PEAC recommended that these codes be reviewed when space permits in the PEAC's future agendas.

CPT Code SS Extracted Medium Descriptors

26125	AAOS	FASCIECTOMY, PARTIAL PALMAR W/ RELEASE, SINGLE DIGIT, ADD'L DIGIT
26861	AAOS	ARTHRODESIS, IP JOINT; ADD'L IP JOINT
26863	AAOS	ARTHRODESIS, IP JOINT W/WO INT FIXATION; W/ AUTOGRAFT, ADD'L JOINT
27692	AAOS	TRANSFER/TRANSPLANT, SINGLE TENDON; ADD'L TENDON
33517	STS	CORONARY ARTERY BYPASS, VENOUS/ARTERIAL GRAFTS; 1 VEIN GRAFT
33518	STS	CORONARY ARTERY BYPASS, VENOUS/ARTERIAL GRAFTS; 2 VENOUS GRAFTS
33519	STS	CORONARY ARTERY BYPASS, VENOUS/ARTERIAL GRAFTS; 3 VENOUS GRAFTS
33521	STS	CORONARY ARTERY BYPASS, VENOUS/ARTERIAL GRAFTS; 4 VENOUS GRAFTS
33522	STS	CORONARY ARTERY BYPASS, VENOUS/ARTERIAL GRAFTS; 5 VENOUS GRAFTS
33523	STS	CORONARY ARTERY BYPASS, VENOUS/ARTERIAL GRAFTS; 6+ VENOUS GRAFTS
33530	STS	REOPERATION, CORONARY ARTERY BYPASS/VALVE PROC, > 1 MONTH POSTOP
64727	AAOS	INT NEUROLYSIS, W/ MICROSCOPE
64778	AAOS	EXCISION, NEUROMA; DIGITAL NERVE, ADD'L DIGIT
64783	AAOS	EXCISION, NEUROMA; HAND/FOOT, ADD'L NERVE, EXCEPT SAME DIGIT
64787	AAOS	IMPLANTATION, NERVE END INTO BONE/MUSCLE
64832	AAOS	SUTURE, DIGITAL NERVE, HAND/FOOT; ADD'L DIGITAL NERVE
64837	AAOS	SUTURE, ADD'L NERVE, HAND/FOOT
64859	AAOS	SUTURE, ADD'L MAJOR PERIPHERAL NERVE
64872	AAOS	SUTURE, NERVE; W/ SECONDARY/DELAYED SUTURE
64874	AAOS	SUTURE, NERVE; W/ EXTENSIVE MOBILIZATION/TRANSPOSITION, NERVE

Approved at the February 1 – 3, 2002 RUC Meeting.

64876	AAOS	SUTURE, NERVE; W/ SHORTENING, BONE, EXTREMITY
64901	AAOS	NERVE GRAFT (INCLUDES OBTAINING GRAFT), ADD'L NERVE; SINGLE STRAND
64902	AAOS	NERVE GRAFT (INCLUDES OBTAINING GRAFT), ADD'L NERVE; MULTIPLE STRANDS
90781	ASTRO	IV INFUSION THERAPY/DX, GIVEN BY/UNDER DIRECTION, PHYSICIAN; EACH ADD'L HR,
96412	ASTRO	CHEMOTHERAPY, IV; INFUSION, 1-8 HR, ADD'L HR
96423	ASTRO	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION, 1-8 HR, ADD'L HR

During the discussion of the above 26 codes, representatives from AANS, CNS, and NASS asked that the PEAC extract an additional group of codes. The PEAC recommended that the specialty write a letter to the PEAC identifying the codes they would like to extract, as a request for reconsideration since the PEAC has already refined and recommended to CMS that these codes have no inputs in the facility setting. The specialty societies agreed, and will present the letter with the codes to the PEAC for discussion at the next meeting.

Practice Expense Inputs for ZZZ Codes

The PEAC discussed the issue of assigning inputs to add on codes in the facility setting. Since the inception of add on codes, the RUC has valued the physician work as only the incremental intra-service work associated with the code and any pre-service or post-service work associated with the code has never been included in the work value of the procedure. Currently, The RUC survey defines ZZZ codes as “ reported in addition to a primary procedure and only the additional intra-service work to perform this service is included in the work RVU”.

The AAOS PEAC representative proposed for discussion purposes that for a number of orthopedic surgery ZZZ codes, an additional level two office visit was associated with each code. Both the AAOS and STS representatives stated that when performing some add on procedures, the amount of work involved goes beyond just the intra-service work, and will also require a separate post-operative visit that is directly related to the add on code. The PEAC discussed this issue and concluded that since any recommendation on the practice expense inputs would have implications for the physician work associated with ZZZ codes, the PEAC referred the issue to the RUC. Specifically, the PEAC passed the following motion:

The PEAC requests the RUC to review the definition of ZZZ codes to determine if it is inconsistent with clinical practice.

The Research Subcommittee should discuss whether for either work or for practice expense purposes, the current definition of ZZZ codes should be changed to reflect additional post-service work that may be associated with ZZZ codes.

Development of Code Families

The PEAC once again discussed the purpose of code family development. A PEAC member was concerned that developing families meant that all codes within a family, then needed to have the same inputs. Doctor Moran explained it was not the intent of the PEAC, to have specialty societies group codes solely on the basis of those having the same inputs, but rather on the types of procedures and CPT code book families. The purpose of creating code families is to; refine large groups of codes quickly, allow the comparison of inputs among codes within and among families, prevent rank order anomalies, and maintain relativity. It was up to the specialty societies to define a code

family since they are most familiar with the codes they provide. It was further explained that specialty societies should group similar type procedures, and not group codes solely on the basis of similar or identical practice expense inputs.

Codes Without Input From Specialties

There were 14 top ten codes where specialty societies hadn't provided the PEAC with a specific family prior to the August 2001 PEAC meeting. These codes were: 15823, 19160, 19240, 36000, 36620, 36800, 66761, 86580, 92065, 92070, 92283, 96100, 96117, and 99183. During the meeting, the PEAC refined code 99183 as no change to its existing inputs, and scheduled the remaining 13 for codes for review during the year 2002.

Different Code Families

At the time of the August 2001 meeting, there were nine code families that needed further review by specialty societies since the code families share common codes but all codes in the family were not the same. This occurred when a code appeared in multiple code families and could result in the same code having multiple direct input recommendations. To prevent this, it will be important for specialty societies to come to agreement on the direct inputs for these codes prior to presenting at the PEAC. During the meeting, Doctor Moran advised specialties again to work together in developing code families and practice expense recommendations. At the time of the August 2001 PEAC meeting, the following top ten code families had at least one code in more than one family: 22554, 22614, 44140, 46934, 49505, 47563, 62311, 63030, 63075, 70300, 70330, 71010, 74022, 76536, 76770, 76830, 90780, 90781, 93880, 96400. Specialty societies were asked to resolve any inconsistencies prior to the issuance of the level of interest forms.

Requests by Specialty Societies

From the PEAC's top ten code families selection process, specialty societies requested 10 codes to be exempt from review. Each of these 10 codes were discussed, and the PEAC made the following recommendations:

Code	PEAC Action
99199	Unlisted Code – No PE Inputs
41899	Unlisted Code – No PE Inputs
95951	Voted N/A for PE inputs in the office setting
94657	No inputs in the office setting, if performed in the office (rare), paid at facility rate. Specialty to come back with PE inputs for the facility setting.
31622	No inputs in the office setting, if performed in the office (rare), paid at facility rate. Specialty to come back with PE inputs for the facility setting.
94375	Specialty to come back to PEAC with recommendation at later date.
95004	Specialty to come back to PEAC with recommendation at later date.
94260	Specialty to come back to PEAC with recommendation at later date.
36600	Specialty to come back to PEAC with recommendation at later date.
94360	Specialty to come back to PEAC with recommendation at later date.

Schedule for Presenting Codes

A tentative draft schedule, developed by staff, for presenting code families was discussed by the PEAC. The PEAC accepted the schedule with minor changes and the caveat of specialties being able to expand or contract a particular family of codes to prevent rank order anomalies. It was noted that a level of interest would be sent out to specialties prior to each of the meetings, and once issued the code families could not change.

Status of Required Codes

In 2000, the PEAC identified codes that were on previous PEAC agenda but had been withdrawn or had not received PEAC approval, or received approval for only some of the inputs. The PEAC identified these codes as required codes, meaning that specialty societies were required to refine the CPEP data for these codes. There are still 51 codes that have not yet been fully refined by the PEAC. The PEAC requested that staff assign these 51 codes to the PEAC's 2002 PE inputs refinement schedule where space permitted.

Code Reconsideration

The PEAC refined code family 11040, 11041, 11042, 11043, 11044 during the March 2001 meeting. The American Association of Orthopaedic Surgeons requested that the PEAC reconsider codes 11043 and 11044 in the out of office setting as the major providers of these services are orthopaedics, general surgery, and plastic surgery, were not sufficiently represented in the practice expense inputs crosswalked by Podiatry. The PEAC allowed for this reconsideration to occur at the January 2002 PEAC meeting.

Post Operative Office Visit Data

During the August 2001 PEAC meeting, several inconsistencies in the physician time databases were identified and are being brought to the attention of the RUC for further review. Earlier in the year, the PEAC proposed and the RUC approved a methodology for refining the CPEP data associated with the post-operative period for codes with 90-day global periods. Specifically, the PEAC agreed that the number and level of office visits currently listed in either the RUC or CMS physician time databases should be multiplied by the approved E/M standard packages. This approach has been used successfully for a number of codes with global periods of 90 and 10 days. During recent meetings, the PEAC has encouraged specialties to present families of codes rather than individual codes to prevent rank order anomalies and facilitate the review of larger numbers of codes, and has therefore, increased the significance of the accuracy of both the RUC and CMS physician time databases.

During the August 2001 PEAC meeting, the American Academy of Orthopedic Surgeons (AAOS) and the North American Spine Society (NASS) refined over 100 codes. However, several inconsistencies in the time database were identified such as inconsistent post-operative visit data within families of codes. The data on the post-operative number and level of office visits are taken from two sources: RUC data (all codes reviewed by the RUC), or CMS's 1998 time file. The RUC database contains both of these sources, however, the RUC considers the RUC data superior to the CMS data. In most cases the inconsistencies are in the CMS data rather than the RUC data.

The PEAC agreed with the presenters that the absence of post-operative office visits in either CMS's time file or in the RUC database, can cause anomalies among families of codes in their practice expense inputs. The PEAC has asked that the RUC Practice Expense Subcommittee review the following issues related to inconsistent visit data:

- Four codes were identified by AAOS as lacking inputs for post-operative office visits in the global package (29850, 29851, 29855, 29856). The AAOS stated that the absence of visit data creates inconsistencies in this family of codes since other codes do include post-operative visits listed. None of these codes have been reviewed by the RUC, so the source of the time visit data is from CMS. The PEAC agreed that these codes should have post-operative office visits as suggested by the AAOS crosswalks. The committee recommends that this issue be forwarded to the RUC practice expense subcommittee, which has responsibility for issues relating to physician time and visit data. The PEAC recommends the following crosswalks:

CODE MISSING DATA	REFERENCE CODE	VISITS	RATIONAL
29850	29886	.5 x 99238; 3 x 99213	Similar post operative care
29851	29885	.5 x 99238; 3.5 x 99213	Similar post operative care
29855	29885	.5 x 99238; 3.5 x 99213	Similar post operative care
29856	29885	.5 x 99238; 3.5 x 99213	Similar post operative care

- The AAOS also pointed out inconsistencies in the physician time database regarding discharge day management services. A number of orthopedic surgery outpatient procedures include .5 of a discharge day management service, however, there are 24 codes that do not include any discharge day management services in the global package. Most of the 24 codes have not been reviewed by the RUC, with the exception of 29848, 29860, 29861, 29862, 29863, 29891, 29892, 29893. The AAOS recommends that .5 of code 99238 should be applied to the 24 codes to be consistent with the other codes in the family. The PEAC agreed with the AAOS proposal and recommends referring this issue to the RUC PE subcommittee for further review. The following codes do not contain an input for 99238:

29815, 29830, 29834, 29835, 29836, 29837, 29840, 29843, 29844, 29845, 29846, 29847, 29848, 29860, 29861, 29862, 29863, 29870, 29875, 29877, 29881, 29891, 29892, 29893.

- A number of the 10-day global codes in the Destruction by Neurolytic agent family that were presented by NASS have one 99212 visit assigned to the global package while other codes in the same family do not have any postoperative visits assigned. To correct this inconsistency in the physician time database, the PEAC recommends that the RUC practice expense subcommittee incorporate one 99212 visit to those codes in this family that currently do not have any visits included in the global

package. Only two of the codes in this family have been reviewed by the RUC: codes 64626 and 64614. And two other codes are listed in the CMS time database as having one 99212 post-operative visit: codes 64600 and 64630. The PEAC recommends that each code in the family: 62280, 62281, 62282, 64600, 64612, 64613, 64614, and 64630 include one 99212 visit in the global package.

- The NASS presenters also pointed out inconsistencies in the physician time database regarding discharge day management services. Only one code in the family included a 99238 visit in the global package. *Destruction. by neurolytic agent, paravertebral facet joint nerve, cervical, thoracic, single level* code 64626 was reviewed by the RUC in May 1999. In addition to code 64626, the only other code in this family that has been reviewed by the RUC *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* code 64614, does not include a discharge day visit. To be consistent, the PEAC felt that a .5 of a discharge day management service should be added to this family of codes. The PEAC recommends that the RUC PE subcommittee review this issue. The following codes in the family do not contain a discharge day management visit and the PEAC recommends the inclusion of half of a discharge day visit for the following codes: 62280, 62281, 62282, 64600, 64605, 64610, 64612, 64613, 64614, 64620, 64622, 64630, 64640, and 64680.
- The PEAC also recommended the practice expense subcommittee review the post-operative time for code 77789 *Surface application of radiation source*. Code 77789 is a 90 day global code that has never been reviewed by the RUC, and CMS's physician time data does not include any post operative hospital or office visit time, only base time. The American Society for Therapeutic Radiology and Oncology (ASTRO) and the American College of Radiology (ACR) are seeking 2 office visits totaling 32 minutes of clinical labor time, the equivalent of two 99211 office visits. The PEAC, however, did not make a specific recommendation for this issue as it was determined to be sufficiently different from the previous issues involving families of codes.
- In addition, the PEAC identified physician time inconsistency between two codes, and have asked the practice expense subcommittee to review the post-operative office time for each. The committee was concerned that code 29893 *Endoscopic plantar fasciotomy*, surveyed by the RUC, has 6 post operative office visits while the open procedure, code 28060 *Fasciectomy, plantar fascia; partial (separate procedure)* (from CMS's contracted Dan Dunn analyses) has 3.5 office visits. The PEAC has asked the practice expense subcommittee to review this issue.

Conscious Sedation

At the August 2001 PEAC meeting, the North American Spine Society (NASS) presented practice expense inputs related to conscious sedation inherent in spine injection procedures. A workgroup of the PEAC reviewed the spine injection practice expense inputs, including these conscious sedation inputs, and developed a standard package to be used related to conscious sedation. The PEAC determined that conscious sedation of a

patient was defined in terms of its potential to compromise the patient's ability to protect the airway and the need for continuous monitoring by a RN who has no other responsibilities. The primary function of the RN is to administer medication, sedate and monitor the patient during and after the procedure. For those codes where it was agreed that conscious sedation is typically used, the PEAC recommended adding RN time of 2 minutes for initiating sedation for the patient, time equal to the physician's intra-service time for monitoring the patient during the procedure, and 15 minutes of follow-up monitoring for each hour monitored following the procedure.

The package for conscious sedation for the injection codes where it was determined that conscious sedation is an inherent component of the procedure is as follows:

Spine Injection Conscious Sedation Package

Clinical Labor:

RN – 2 minutes to initiate sedation

RN – The physician intra-service time for monitoring during the procedure

RN – 15 minutes of follow-up monitoring for each hour monitored following the procedure.

Medical Supplies:

Pulse oximeter probe

gown, staff

gloves (sterile)

swab alcohol (2)

band aid

Guaze, sterile, 4x4 (4)

tape, 6 inches (12)

Tegaderm dressing 4x4 ¾

oxygen, 1 ltr (200)

ECG electrodes disposable

angiocatheter 20 to 25g

IV inusion set

stopcock, 3 way

IV starter kit

syringe, 3 cc, 20 to 25 g (2)

syringe, 1 ml

rubber tourniquet

suction tip catheter

O2 mask and tubing

Medical Equipment:

cardio-respiratory monitor

infusion pump

pulse oximeter

oxygen tank

In addition to the conscious sedation package the pre-facilitation committee utilized a basic injection supply package.

Basic Injection Package (In-Office Supplies)

Chux	1 item	11102
Gown, impervious, staff	1 item	11304
Surgical cap	1 item	11305
Surgical mask	1 item	11306
Drape, sterile, mayo	1 item	14003
Gloves (sterile)	2 items	14005
Drape, sterile, fenestrated	1 item	14007
Sterile surgical gown, disposable	1 item	14008
Betadine	10cc	52301
Sponge tip applicator	3 items	31110
Sterile gauze	2 items	31508
Band-Aid	1 item	31502
Needle 18-24 gauge	1 item	91402
Needle 25-26 gauge	1 item	91403
Syringe 3 cc	1 item	91415
Xylocaine 1% 20 ml	5 cc	51503

**AMA/Specialty Society RVS Update Committee
Practice Expense Advisory Committee
Pre-Service Time Workgroup**

Pre-Service Standard for 90 day Global Period

The workgroup, consisting of Doctors Templeton (chair), Felger, Kaufman, Przyblyski, Ouzounian, Paganini, Regan, and Katherine Bradley, RhD, RN met three times to discuss the PEAC approved pre-service standard times for codes with global periods of 90 days. The PEAC asked the workgroup to determine criteria for specialty societies to use when requesting time greater than the 60 and 35 minute standard.

When the workgroup initially developed the standard times of 35 and 60 minutes, the workgroup discussed the possibility of developing multiple standard times, however, the workgroup was unable to develop a methodology for multiple standards. Instead, the workgroup constructed single standard of 60 minutes for the facility setting and 35 minutes for the out of office setting. In March, the PEAC approved that these times should be applied to all 90-day global codes after a year. During this time, specialty societies would have an opportunity to identify outliers to the standard. The workgroup was asked to develop criteria that specialty societies could follow when presenting pre-service time considered to be outliers.

In an effort to develop guidelines to assist specialty societies, the workgroup first reviewed the pre-service standard that has been accepted by the PEAC. The workgroup reconfirmed that the standard times were averages based on various types of procedures and accounted for the variability in pre-service time among codes. For example, sometimes a procedure will require almost zero clinical staff time for an emergent procedure, while on other occasions the time will exceed the standards. However, the workgroup feels that the standards represent average pre-service times that apply to most 90 day global codes.

The workgroup discussed various methods for determining outliers. One proposal was to use physician intra-service times as a proxy to identify outliers that may be less than or greater than the standard time. The workgroup rejected the use of physician intra-service time because it was felt that it would not accurately identify outliers of clinical staff pre-service time. The workgroup did not agree that the pre-service clinical time varied according to the intra-service physician time.

Another proposal was to develop specific criteria specialties could follow for either justifying the pre-service time standards as well and justifying time greater than the standards. This would recognize that most codes are covered by the standard, but there are codes with pre-service times less than and greater than the standard. The workgroup would then have to define the necessary criteria. Other workgroup members felt that the individual specialty societies should have to justify times greater than the standard by examining each of the clinical staff activities and explain why the time requested is greater than the standard.

Another option discussed was to allow specialty societies additional time for codes as long as any increases above the standards were exactly offset by decreases. Any increase in time (pre-service time multiplied by code frequency) would have to match decreases to other codes. The workgroup felt this was a possible solution except there may be some specialties that may not have a sufficient number of codes with times lower than the standard that would allow them to offset any increases. The issue of those specialties that may have most of their codes with times below the standards was also discussed. Some felt that this methodology would not identify such codes below the standard and then other specialties with predominately higher pre-service times would be adversely affected.

The workgroup discussed the possibility of developing additional standards, one below and one above the 60 minute standard. One workgroup member felt that there was sufficient variability in the pre-service work of 90 day global codes to justify several levels of time standards. However, the workgroup could not develop a methodology for identifying codes for placement in the various pre-service time categories.

After considerable discussion and review of various alternatives the workgroup came to the following conclusion and recommendation:

The workgroup reaffirmed its acceptance of the pre-service time standards (60 and 35 minutes) and that these standards reflect an average time that covers the vast majority of 90-day global procedures. The consensus of the Workgroup was that there may be codes with pre-service times greater than the standard but the workgroup was unable to develop a methodology for identifying such outliers. The workgroup recommends that if a specialty society believes that additional time is warranted for particular codes, the society should use the PEAC template and justify the additional time on a line by line basis by examining each staff activity and include a comparison to the approved standard times.

Neurosurgery Pre Service Clinical Staff Time Recommendations

CPT Code	Short descriptor	Global	Recommended	Specialty Family
20660	APPLY,REMOVE FIXATION DEVICE	90	60 Minutes	Cranial/Spinal Minor
20661	APPLICATION OF HEAD BRACE	90	60 Minutes	Cranial/Spinal Minor
20662	APPLICATION OF PELVIS BRACE	90	60 Minutes	Cranial/Spinal Minor
20663	APPLICATION OF THIGH BRACE	90	60 Minutes	Cranial/Spinal Minor
20664	HALO BRACE APPLICATION	90	60 Minutes	Cranial/Spinal Minor
22100	REMOVE PART OF NECK VERTEBRA	90	60 Minutes	Routine Spine
22101	REMOVE PART, THORAX VERTEBRA	90	60 Minutes	Routine Spine
22102	REMOVE PART, LUMBAR VERTEBRA	90	60 Minutes	Routine Spine
22110	REMOVE PART OF NECK VERTEBRA	90	60 Minutes	Routine Spine
22112	REMOVE PART, THORAX VERTEBRA	90	60 Minutes	Routine Spine
22114	REMOVE PART, LUMBAR VERTEBRA	90	60 Minutes	Routine Spine
22210	REVISION OF NECK SPINE	90	75 minutes	Complex Spine
22212	REVISION OF THORAX SPINE	90	75 minutes	Complex Spine
22214	REVISION OF LUMBAR SPINE	90	75 minutes	Complex Spine
22220	REVISION OF NECK SPINE	90	75 minutes	Complex Spine
22222	REVISION OF THORAX SPINE	90	75 minutes	Complex Spine
22224	REVISION OF LUMBAR SPINE	90	75 minutes	Complex Spine
22305	TREAT SPINE PROCESS FRACTURE	90	60 Minutes	Cranial/Spinal Minor
22310	TREAT SPINE FRACTURE	90	60 Minutes	Cranial/Spinal Minor
22315	TREAT SPINE FRACTURE	90	60 Minutes	Cranial/Spinal Minor
22318	TREAT ODONTOID FX W/O GRAFT	90	60 Minutes	Routine Spine
22319	TREAT ODONTOID FX W/GRAFT	90	60 Minutes	Routine Spine
22325	TREAT SPINE FRACTURE	90	60 Minutes	Routine Spine
22326	TREAT NECK SPINE FRACTURE	90	60 Minutes	Routine Spine
22327	TREAT THORAX SPINE FRACTURE	90	60 Minutes	Routine Spine
22548	NECK SPINE FUSION	90	75 minutes	Complex Spine
22554	NECK SPINE FUSION	90	75 minutes	Complex Spine
22556	THORAX SPINE FUSION	90	75 minutes	Complex Spine
22558	LUMBAR SPINE FUSION	90	75 minutes	Complex Spine
22590	SPINE & SKULL SPINAL FUSION	90	75 minutes	Complex Spine
22595	NECK SPINAL FUSION	90	75 minutes	Complex Spine
22600	NECK SPINE FUSION	90	75 minutes	Complex Spine
22610	THORAX SPINE FUSION	90	75 minutes	Complex Spine
22612	LUMBAR SPINE FUSION	90	75 minutes	Complex Spine
22630	LUMBAR SPINE FUSION	90	75 minutes	Complex Spine
22800	FUSION OF SPINE	90	75 minutes	Complex Spine
22802	FUSION OF SPINE	90	75 minutes	Complex Spine
22804	FUSION OF SPINE	90	75 minutes	Complex Spine
22808	FUSION OF SPINE	90	75 minutes	Complex Spine
22810	FUSION OF SPINE	90	75 minutes	Complex Spine
22812	FUSION OF SPINE	90	75 minutes	Complex Spine
22818	KYPHECTOMY, 1-2 SEGMENTS	90	75 minutes	Complex Spine
22819	KYPHECTOMY, 3 OR MORE	90	75 minutes	Complex Spine
22830	EXPLORATION OF SPINAL FUSION	90	60 Minutes	Routine Spine
22849	REINSERT SPINAL FIXATION	90	60 Minutes	Routine Spine
22850	REMOVE SPINE FIXATION DEVICE	90	60 Minutes	Routine Spine

22852	REMOVE SPINE FIXATION DEVICE	90	60 Minutes	Routine Spine
22855	REMOVE SPINE FIXATION DEVICE	90	60 Minutes	Routine Spine
61000	REMOVE CRANIAL CAVITY FLUID	90	60 Minutes	Cranial/Spinal Minor
61001	REMOVE CRANIAL CAVITY FLUID	90	60 Minutes	Cranial/Spinal Minor
61020	REMOVE BRAIN CAVITY FLUID	90	60 Minutes	Cranial/Spinal Minor
61026	INJECTION INTO BRAIN CANAL	90	60 Minutes	Cranial/Spinal Minor
61050	REMOVE BRAIN CANAL FLUID	90	60 Minutes	Cranial/Spinal Minor
61055	INJECTION INTO BRAIN CANAL	90	60 Minutes	Cranial/Spinal Minor
61070	BRAIN CANAL SHUNT PROCEDURE	90	60 Minutes	Cranial/Spinal Minor
61105	TWIST DRILL HOLE	90	60 Minutes	Cranial/Spinal Minor
61107	DRILL SKULL FOR IMPLANTATION	90	60 Minutes	Cranial/Spinal Minor
61108	DRILL SKULL FOR DRAINAGE	90	60 Minutes	Cranial/Spinal Minor
61120	BURR HOLE FOR PUNCTURE	90	60 Minutes	Cranial/Spinal Minor
61140	PIERCE SKULL FOR BIOPSY	90	60 Minutes	Cranial/Spinal Minor
61150	PIERCE SKULL FOR DRAINAGE	90	60 Minutes	Cranial/Spinal Minor
61151	PIERCE SKULL FOR DRAINAGE	90	60 Minutes	Cranial/Spinal Minor
61154	PIERCE SKULL & REMOVE CLOT	90	60 Minutes	Cranial/Spinal Minor
61156	PIERCE SKULL FOR DRAINAGE	90	60 Minutes	Cranial/Spinal Minor
61210	PIERCE SKULL, IMPLANT DEVICE	90	60 Minutes	Cranial/Spinal Minor
61215	INSERT BRAIN-FLUID DEVICE	90	60 Minutes	Cranial/Spinal Minor
61250	PIERCE SKULL & EXPLORE	90	60 Minutes	Cranial/Spinal Minor
61253	PIERCE SKULL & EXPLORE	90	60 Minutes	Cranial/Spinal Minor
61304	OPEN SKULL FOR EXPLORATION	90	75 minutes	Cranial Major
61305	OPEN SKULL FOR EXPLORATION	90	75 minutes	Cranial Major
61312	OPEN SKULL FOR DRAINAGE	90	75 minutes	Cranial Major
61313	OPEN SKULL FOR DRAINAGE	90	75 minutes	Cranial Major
61314	OPEN SKULL FOR DRAINAGE	90	75 minutes	Cranial Major
61315	OPEN SKULL FOR DRAINAGE	90	75 minutes	Cranial Major
61320	OPEN SKULL FOR DRAINAGE	90	75 minutes	Cranial Major
61321	OPEN SKULL FOR DRAINAGE	90	75 minutes	Cranial Major
61330	DECOMPRESS EYE SOCKET	90	75 minutes	Cranial Major
61332	EXPLORE/BIOPSY EYE SOCKET	90	75 minutes	Cranial Major
61333	EXPLORE ORBIT/REMOVE LESION	90	75 minutes	Cranial Major
61334	EXPLORE ORBIT/REMOVE OBJECT	90	75 minutes	Cranial Major
61340	RELIEVE CRANIAL PRESSURE	90	75 minutes	Cranial Major
61343	INCISE SKULL (PRESS RELIEF)	90	75 minutes	Cranial Major
61345	RELIEVE CRANIAL PRESSURE	90	75 minutes	Cranial Major
61440	INCISE SKULL FOR SURGERY	90	75 minutes	Cranial Major
61450	INCISE SKULL FOR SURGERY	90	75 minutes	Cranial Major
61458	INCISE SKULL FOR BRAIN WOUND	90	75 minutes	Cranial Major
61460	INCISE SKULL FOR SURGERY	90	75 minutes	Cranial Major
61470	INCISE SKULL FOR SURGERY	90	75 minutes	Cranial Major
61480	INCISE SKULL FOR SURGERY	90	75 minutes	Cranial Major
61490	INCISE SKULL FOR SURGERY	90	75 minutes	Cranial Major
61500	REMOVAL OF SKULL LESION	90	75 minutes	Cranial Major
61501	REMOVE INFECTED SKULL BONE	90	75 minutes	Cranial Major
61510	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61512	REMOVE BRAIN LINING LESION	90	75 minutes	Cranial Major
61514	REMOVAL OF BRAIN ABSCESS	90	75 minutes	Cranial Major
61516	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major

61518	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61519	REMOVE BRAIN LINING LESION	90	75 minutes	Cranial Major
61520	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61521	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61522	REMOVAL OF BRAIN ABSCESS	90	75 minutes	Cranial Major
61524	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61526	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61530	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61531	IMPLANT BRAIN ELECTRODES	90	75 minutes	Cranial Major
61533	IMPLANT BRAIN ELECTRODES	90	75 minutes	Cranial Major
61534	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61535	REMOVE BRAIN ELECTRODES	90	75 minutes	Cranial Major
61536	REMOVAL OF BRAIN LESION	90	75 minutes	Cranial Major
61538	REMOVAL OF BRAIN TISSUE	90	75 minutes	Cranial Major
61539	REMOVAL OF BRAIN TISSUE	90	75 minutes	Cranial Major
61541	INCISION OF BRAIN TISSUE	90	75 minutes	Cranial Major
61542	REMOVAL OF BRAIN TISSUE	90	75 minutes	Cranial Major
61543	REMOVAL OF BRAIN TISSUE	90	75 minutes	Cranial Major
61544	REMOVE & TREAT BRAIN LESION	90	75 minutes	Cranial Major
61545	EXCISION OF BRAIN TUMOR	90	75 minutes	Cranial Major
61546	REMOVAL OF PITUITARY GLAND	90	75 minutes	Cranial Major
61548	REMOVAL OF PITUITARY GLAND	90	75 minutes	Cranial Major
61550	RELEASE OF SKULL SEAMS	90	75 minutes	Cranial Major
61552	RELEASE OF SKULL SEAMS	90	75 minutes	Cranial Major
61556	INCISE SKULL/SUTURES	90	75 minutes	Cranial Major
61557	INCISE SKULL/SUTURES	90	75 minutes	Cranial Major
61558	EXCISION OF SKULL/SUTURES	90	75 minutes	Cranial Major
61559	EXCISION OF SKULL/SUTURES	90	75 minutes	Cranial Major
61563	EXCISION OF SKULL TUMOR	90	75 minutes	Cranial Major
61564	EXCISION OF SKULL TUMOR	90	75 minutes	Cranial Major
61570	REMOVE FOREIGN BODY, BRAIN	90	75 minutes	Cranial Major
61571	INCISE SKULL FOR BRAIN WOUND	90	75 minutes	Cranial Major
61575	SKULL BASE/BRAINSTEM SURGERY	90	75 minutes	Cranial Major
61576	SKULL BASE/BRAINSTEM SURGERY	90	75 minutes	Cranial Major
61580	CRANIOFACIAL APPROACH, SKULL	90	75 minutes	Skull Base
61581	CRANIOFACIAL APPROACH, SKULL	90	75 minutes	Skull Base
61582	CRANIOFACIAL APPROACH, SKULL	90	75 minutes	Skull Base
61583	CRANIOFACIAL APPROACH, SKULL	90	75 minutes	Skull Base
61584	ORBITOCRANIAL APPROACH/SKULL	90	75 minutes	Skull Base
61585	ORBITOCRANIAL APPROACH/SKULL	90	75 minutes	Skull Base
61586	RESECT NASOPHARYNX, SKULL	90	75 minutes	Skull Base
61590	INFRA TEMPORAL APPROACH/SKULL	90	75 minutes	Skull Base
61591	INFRA TEMPORAL APPROACH/SKULL	90	75 minutes	Skull Base
61592	ORBITOCRANIAL APPROACH/SKULL	90	75 minutes	Skull Base
61595	TRANSTEMPORAL APPROACH/SKULL	90	75 minutes	Skull Base
61596	TRANSCOCHLEAR APPROACH/SKULL	90	75 minutes	Skull Base
61597	TRANSCONDYLAR APPROACH/SKULL	90	75 minutes	Skull Base

61598	TRANSPETROSAL APPROACH/SKULL	90	75 minutes	Skull Base
61600	RESECT/EXCISE CRANIAL LESION	90	75 minutes	Skull Base
61601	RESECT/EXCISE CRANIAL LESION	90	75 minutes	Skull Base
61605	RESECT/EXCISE CRANIAL LESION	90	75 minutes	Skull Base
61606	RESECT/EXCISE CRANIAL LESION	90	75 minutes	Skull Base
61607	RESECT/EXCISE CRANIAL LESION	90	75 minutes	Skull Base
61608	RESECT/EXCISE CRANIAL LESION	90	75 minutes	Skull Base
61613	REMOVE ANEURYSM, SINUS	90	75 minutes	Skull Base
61615	RESECT/EXCISE LESION, SKULL	90	75 minutes	Skull Base
61616	RESECT/EXCISE LESION, SKULL	90	75 minutes	Skull Base
61618	REPAIR DURA	90	75 minutes	Skull Base
61619	REPAIR DURA	90	75 minutes	Skull Base
61624	OCCLUSION/EMBOLIZATION CATH	90	75 minutes	Cranial Major
61626	OCCLUSION/EMBOLIZATION CATH	90	75 minutes	Cranial Major
61680	INTRACRANIAL VESSEL SURGERY	90	75 minutes	Cranial Major
61682	INTRACRANIAL VESSEL SURGERY	90	75 minutes	Cranial Major
61684	INTRACRANIAL VESSEL SURGERY	90	75 minutes	Cranial Major
61686	INTRACRANIAL VESSEL SURGERY	90	75 minutes	Cranial Major
61690	INTRACRANIAL VESSEL SURGERY	90	75 minutes	Cranial Major
61692	INTRACRANIAL VESSEL SURGERY	90	75 minutes	Cranial Major
61697	BRAIN ANEURYSM REPR, COMPLX	90	75 minutes	Cranial Major
61698	BRAIN ANEURYSM REPR, COMPLX	90	75 minutes	Cranial Major
61700	BRAIN ANEURYSM REPR , SIMPLE	90	75 minutes	Cranial Major
61702	INNER SKULL VESSEL SURGERY	90	75 minutes	Cranial Major
61703	CLAMP NECK ARTERY	90	75 minutes	Cranial Major
61705	REVISE CIRCULATION TO HEAD	90	75 minutes	Cranial Major
61708	REVISE CIRCULATION TO HEAD	90	75 minutes	Cranial Major
61710	REVISE CIRCULATION TO HEAD	90	75 minutes	Cranial Major
61711	FUSION OF SKULL ARTERIES	90	75 minutes	Cranial Major
61720	INCISE SKULL/BRAIN SURGERY	90	60 Minutes	General Neurosurgery
61735	INCISE SKULL/BRAIN SURGERY	90	60 Minutes	General Neurosurgery
61750	INCISE SKULL/BRAIN BIOPSY	90	60 Minutes	General Neurosurgery
61751	BRAIN BIOPSY W/ CT/MR GUIDE	90	60 Minutes	General Neurosurgery
61760	IMPLANT BRAIN ELECTRODES	90	60 Minutes	General Neurosurgery
61770	INCISE SKULL FOR TREATMENT	90	60 Minutes	General Neurosurgery
61790	TREAT TRIGEMINAL NERVE	90	60 Minutes	General Neurosurgery
61791	TREAT TRIGEMINAL TRACT	90	60 Minutes	General Neurosurgery
61793	FOCUS RADIATION BEAM	90	60 Minutes	Cranial Major
61795	BRAIN SURGERY USING COMPUTER	90	60 Minutes	General Neurosurgery
61850	IMPLANT NEUROELECTRODES	90	60 Minutes	General Neurosurgery
61860	IMPLANT NEUROELECTRODES	90	60 Minutes	General Neurosurgery
61862	IMPLANT NEUROSTIMUL, SUBCORT	90	60 Minutes	General Neurosurgery
61870	IMPLANT NEUROELECTRODES	90	60 Minutes	General Neurosurgery
61875	IMPLANT NEUROELECTRODES	90	60 Minutes	General Neurosurgery
61880	REVISE/REMOVE NEUROELECTRODE	90	60 Minutes	General Neurosurgery
61885	IMPLANT NEUROSTIM ONE ARRAY	90	60 Minutes	General Neurosurgery
61886	IMPLANT NEUROSTIM ARRAYS	90	60 Minutes	General Neurosurgery
61888	REVISE/REMOVE NEURORECEIVER	90	60 Minutes	General Neurosurgery
62000	TREAT SKULL FRACTURE	90	60 Minutes	General Neurosurgery
62005	TREAT SKULL FRACTURE	90	60 Minutes	General Neurosurgery

62010	TREATMENT OF HEAD INJURY	90	60 Minutes	General Neurosurgery
62100	REPAIR BRAIN FLUID LEAKAGE	90	60 Minutes	General Neurosurgery
62115	REDUCTION OF SKULL DEFECT	90	60 Minutes	General Neurosurgery
62116	REDUCTION OF SKULL DEFECT	90	60 Minutes	General Neurosurgery
62117	REDUCTION OF SKULL DEFECT	90	60 Minutes	General Neurosurgery
62120	REPAIR SKULL CAVITY LESION	90	60 Minutes	General Neurosurgery
62121	INCISE SKULL REPAIR	90	60 Minutes	General Neurosurgery
62140	REPAIR OF SKULL DEFECT	90	60 Minutes	General Neurosurgery
62141	REPAIR OF SKULL DEFECT	90	60 Minutes	General Neurosurgery
62142	REMOVE SKULL PLATE/FLAP	90	60 Minutes	General Neurosurgery
62143	REPLACE SKULL PLATE/FLAP	90	60 Minutes	General Neurosurgery
62145	REPAIR OF SKULL & BRAIN	90	60 Minutes	General Neurosurgery
62146	REPAIR OF SKULL WITH GRAFT	90	60 Minutes	General Neurosurgery
62147	REPAIR OF SKULL WITH GRAFT	90	60 Minutes	General Neurosurgery
62180	ESTABLISH BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62190	ESTABLISH BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62192	ESTABLISH BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62194	REPLACE/IRRIGATE CATHETER	90	60 Minutes	General Neurosurgery
62200	ESTABLISH BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62201	ESTABLISH BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62220	ESTABLISH BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62223	ESTABLISH BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62225	REPLACE/IRRIGATE CATHETER	90	60 Minutes	General Neurosurgery
62230	REPLACE/REVISE BRAIN SHUNT	90	60 Minutes	General Neurosurgery
62252	CSF SHUNT REPROGRAM	90	60 Minutes	General Neurosurgery
62256	REMOVE BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62258	REPLACE BRAIN CAVITY SHUNT	90	60 Minutes	General Neurosurgery
62350	IMPLANT SPINAL CANAL CATH	90	60 Minutes	Routine Spine
62351	IMPLANT SPINAL CANAL CATH	90	60 Minutes	Routine Spine
62355	REMOVE SPINAL CANAL CATHETER	90	60 Minutes	Routine Spine
62360	INSERT SPINE INFUSION DEVICE	90	60 Minutes	Routine Spine
62361	IMPLANT SPINE INFUSION PUMP	90	60 Minutes	Routine Spine
62362	IMPLANT SPINE INFUSION PUMP	90	60 Minutes	Routine Spine
62365	REMOVE SPINE INFUSION DEVICE	90	60 Minutes	Routine Spine
63001	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63003	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63005	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63011	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63012	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63015	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63016	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63017	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63020	NECK SPINE DISK SURGERY	90	60 Minutes	Routine Spine
63030	LOW BACK DISK SURGERY	90	60 Minutes	Routine Spine
63040	LAMINOTOMY, SINGLE CERVICAL	90	60 Minutes	Routine Spine
63042	LAMINOTOMY, SINGLE LUMBAR	90	60 Minutes	Routine Spine
63045	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63046	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63047	REMOVAL OF SPINAL LAMINA	90	60 Minutes	Routine Spine
63055	DECOMPRESS SPINAL CORD	90	60 Minutes	Routine Spine

63056	DECOMPRESS SPINAL CORD	90	60 Minutes	Routine Spine
63064	DECOMPRESS SPINAL CORD	90	60 Minutes	Routine Spine
63075	NECK SPINE DISK SURGERY	90	60 Minutes	Routine Spine
63077	SPINE DISK SURGERY, THORAX	90	60 Minutes	Routine Spine
63081	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63085	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63087	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63090	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63170	INCISE SPINAL CORD TRACT(S)	90	75 minutes	Complex Spine
63172	DRAINAGE OF SPINAL CYST	90	75 minutes	Complex Spine
63173	DRAINAGE OF SPINAL CYST	90	75 minutes	Complex Spine
63180	REVISE SPINAL CORD LIGAMENTS	90	75 minutes	Complex Spine
63182	REVISE SPINAL CORD LIGAMENTS	90	75 minutes	Complex Spine
63185	INCISE SPINAL COLUMN/NERVES	90	75 minutes	Complex Spine
63190	INCISE SPINAL COLUMN/NERVES	90	75 minutes	Complex Spine
63191	INCISE SPINAL COLUMN/NERVES	90	75 minutes	Complex Spine
63194	INCISE SPINAL COLUMN & CORD	90	75 minutes	Complex Spine
63195	INCISE SPINAL COLUMN & CORD	90	75 minutes	Complex Spine
63196	INCISE SPINAL COLUMN & CORD	90	75 minutes	Complex Spine
63197	INCISE SPINAL COLUMN & CORD	90	75 minutes	Complex Spine
63198	INCISE SPINAL COLUMN & CORD	90	75 minutes	Complex Spine
63199	INCISE SPINAL COLUMN & CORD	90	75 minutes	Complex Spine
63200	RELEASE OF SPINAL CORD	90	75 minutes	Complex Spine
63250	REVISE SPINAL CORD VESSELS	90	75 minutes	Complex Spine
63251	REVISE SPINAL CORD VESSELS	90	75 minutes	Complex Spine
63252	REVISE SPINAL CORD VESSELS	90	75 minutes	Complex Spine
63265	EXCISE INTRASPINAL LESION	90	75 minutes	Complex Spine
63266	EXCISE INTRASPINAL LESION	90	75 minutes	Complex Spine
63267	EXCISE INTRASPINAL LESION	90	75 minutes	Complex Spine
63268	EXCISE INTRASPINAL LESION	90	75 minutes	Complex Spine
63270	EXCISE INTRASPINAL LESION	90	75 minutes	Complex Spine
63271	EXCISE INTRASPINAL LESION	90	75 minutes	Complex Spine
63272	EXCISE INTRASPINAL LESION	90	75 minutes	Complex Spine
63273	EXCISE INTRASPINAL LESION	90	75 minutes	Complex Spine
63275	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63276	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63277	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63278	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63280	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63281	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63282	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63283	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63285	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63286	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63287	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63290	BIOPSY/EXCISE SPINAL TUMOR	90	75 minutes	Complex Spine
63300	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63301	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63302	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63303	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine

63304	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63305	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63306	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63307	REMOVAL OF VERTEBRAL BODY	90	75 minutes	Complex Spine
63600	REMOVE SPINAL CORD LESION	90	60 Minutes	General Neurosurgery
63610	STIMULATION OF SPINAL CORD	90	60 Minutes	General Neurosurgery
63615	REMOVE LESION OF SPINAL CORD	90	60 Minutes	General Neurosurgery
63650	IMPLANT NEUROELECTRODES	90	60 Minutes	Routine Spine
63655	IMPLANT NEUROELECTRODES	90	60 Minutes	Routine Spine
63660	REVISE/REMOVE NEUROELECTRODE	90	60 Minutes	Routine Spine
63685	IMPLANT NEURORECEIVER	90	60 Minutes	Routine Spine
63688	REVISE/REMOVE NEURORECEIVER	90	60 Minutes	Routine Spine
63700	REPAIR OF SPINAL HERNIATION	90	60 Minutes	General Neurosurgery
63702	REPAIR OF SPINAL HERNIATION	90	60 Minutes	General Neurosurgery
63704	REPAIR OF SPINAL HERNIATION	90	60 Minutes	General Neurosurgery
63706	REPAIR OF SPINAL HERNIATION	90	60 Minutes	General Neurosurgery
63707	REPAIR SPINAL FLUID LEAKAGE	90	60 Minutes	General Neurosurgery
63709	REPAIR SPINAL FLUID LEAKAGE	90	60 Minutes	General Neurosurgery
63710	GRAFT REPAIR OF SPINE DEFECT	90	60 Minutes	General Neurosurgery
63740	INSTALL SPINAL SHUNT	90	60 Minutes	General Neurosurgery
63741	INSTALL SPINAL SHUNT	90	60 Minutes	General Neurosurgery
63744	REVISION OF SPINAL SHUNT	90	60 Minutes	General Neurosurgery
63746	REMOVAL OF SPINAL SHUNT	90	60 Minutes	General Neurosurgery
64573	IMPLANT NEUROELECTRODES	90	60 Minutes	General Neurosurgery
64575	IMPLANT NEUROELECTRODES	90	60 Minutes	General Neurosurgery
64577	IMPLANT NEUROELECTRODES	90	60 Minutes	General Neurosurgery
64580	IMPLANT NEUROELECTRODES	90	60 Minutes	General Neurosurgery
64585	REVISE/REMOVE NEUROELECTRODE	90	60 Minutes	General Neurosurgery
64590	IMPLANT NEURORECEIVER	90	60 Minutes	General Neurosurgery
64595	REVISE/REMOVE NEURORECEIVER	90	60 Minutes	General Neurosurgery

**AMA/Specialty Society RVS Update Committee
Multi-Specialty Points of Comparison Workgroup**
January 31, 2002

The Multi-Specialty Points of Comparison (MPC) Workgroup met on Thursday, January 31, 2002 to review a list of 286 CPT codes nominated by specialty societies for consideration on the RUC's new MPC. The following RUC members were in attendance: Charles Koopmann, MD (Chair), Stephen Bauer, MD, William Gee, MD, Meghan Gerety, MD, James Hayes, MD, Jerilyn Kaibel, DC, J. Leonard Lichtenfeld, MD, David McCaffree, MD, and Bernard Pfeifer, MD.

Criteria for Inclusion on the MPC

The workgroup and the RUC have previously approved the following criteria for inclusion on the MPC:

Absolute Criteria:

- The codes should have current work RVUs that the specialty(s) accept as valid and that have been implemented by CMS.
- The specialty(s) that perform a significant percentage of the service should have the right to review the appropriateness of the inclusion of the service on the MPC
- Any code included in the MPC list should have gone through the RUC survey process and have RUC approved time.

Other Suggested Criteria (not Absolute Requirements):

- Codes submitted should represent a range of low to high work RVUs within the specialty's services.
- The submitted codes should include the range of global periods for services provided by the specialty.
- Codes should be reflective of the entire spectrum of services provided by a specialty society.
- Codes that are frequently performed should be reflected on the MPC.
- To the maximum extent possible, the MPC list should include codes that are performed by multiple specialties.
- Codes on the MPC should be understood and familiar to most physicians

The RUC has also previously approved the workgroup's recommendation that the MPC should be established based on the absolute criteria (listed above). Other codes that a specialty accepts as valid may be added and identified with a separate designation.

The RUC recommends that each code on a single MPC list be designated with an indicator as follows:

A = The code meets all of the absolute criteria.

B = The code does not have RUC time data available, however, the code is performed by several specialties and is well understood by many physicians.

C = The code does not have RUC time data available, however the specialty society would like the code included as a reference point.

The workgroup reviewed the compiled list and categorized the codes. 183 services were designated as an A; 31 services were designated as a B; and 60 services were designated a C. Twelve services were extracted from the list for the following reasons:

76519	Service may not describe physician work
92585	Service may not describe physician work
95144	Similar service with same work RVU included on MPC
95145	Similar service with same work RVU included on MPC
99141	Conscious sedation under review currently by the RUC
99296	Tabled until NICU codes relative values are finalized
99297	Tabled until NICU codes relative values are finalized
99381	Similar service with same work RVU included on MPC
99383	Similar service with same work RVU included on MPC
99384	Similar service with same work RVU included on MPC
99393	Similar service with same work RVU included on MPC
99394	Similar service with same work RVU included on MPC

The workgroup plans to distribute this list again so that specialties can review the designation and may petition the MPC workgroup via letter if they disagree with the designation for their codes. The workgroup will meet via conference call to review any requested revisions. The final MPC list will then be submitted to the RUC in April for approval.

The workgroup briefly discussed the plans to review the MPC in the future. In general, the workgroup agreed that the MPC list should be reviewed after each Five-Year Review of the RBRVS. The workgroup also agreed that specialties may solicit the RUC to add or replace codes on the MPC, but should have adequate rationale to do so. The workgroup again clarified that inclusion on the MPC does not preclude a specialty from commenting on that code in a future Five-Year Review.

RUC HCPAC Review Board Report

The Pointe at South Mountain

Phoenix, Arizona

January 31, 2002

On January 31, 2002, the RUC HCPAC Board met to review issues related to the Gait and Motion Studies and the survey process for psychology codes. The following HCPAC Review Board members participated in the discussion:

Richard Whitten, MD, Chair
Don E. Williamson, OD, Co-Chair
Eileen Sullivan-Marx, PhD
Mary Foto, OTR
James Georgoulakis, PhD
James E. Hayes, MD
Marc D. Lenet, DPM
Samuel M. Brown, PT
Arthur Traugott, MD
Steven White, PhD
Nelda Spryes, LCSW
Emily Hill, PA-C
Jerilynn Kaibel, DC
Karen Smith, MS, RD, FAD

I. Call to Order

Dr. Williamson called the meeting to order at 12:00 p.m.

II. Gait and Motion Studies

The Review Board considered a letter and presentation from the American Physical Therapy Association. The presentation centered around four codes: 96000, 96001, 96002 and 96003, which describe gait and motion studies. Due to a flaw in the survey process, the validity and accuracy of the pre-, intra- and post-service times were questioned. The RUC HCPAC considered this flawed data and rejected the APTA recommendations.

CMS has published the following work values as interim in 2002:

96000	1.80
96001	2.15
96002	0.41
96003	0.37

The Review Board recommends maintaining the current values assigned by CMS until more accurate survey data is obtained. The APTA added that they would consult the

Approved at the February 1 – 3, 2002 RUC Meeting.

Clinical Gait and Movement Analysis Society for further information regarding the time data.

It was noted that there is no practice expense because these codes are done within a facility.

III. Explanation of Survey Process

The American Psychological Association has proposed a customized survey to be utilized in surveying psychological and neuropsychological assessment services (CPT codes 96100-96117). The Review Board made several suggestions regarding the proposed survey.

The Review Board recommends that APA propose a draft survey with these suggested changes to the Research Subcommittee at the April meeting or by conference call. It was also noted that a proposed reference service list must accompany the proposed survey instrument when it is reviewed by the Research Subcommittee.

IV. Adjournment

The meeting was adjourned at 1:15 p.m.

**AMA/Specialty Society RVS Update Committee
The Pointe at South Mountain, Phoenix, Arizona
Practice Expense Subcommittee Report
Thursday, January 31, 2002**

The Practice Expense Subcommittee met January 31, 2002 to discuss four issues relating to physician time, and CMS's zero work pool methodology. The following subcommittee members participated: Doctors Levy (Chair), Gage, Gerety, Lichtenfeld, McCaffree, Moran, and Sam Brown, PT.

Minutes of September 19, 2001 Conference Call and RUC Actions

The RUC reviewed and approved the minutes from the subcommittee's previous conference call meeting on September 19, 2001.

Physician Time Ground Rules

CMS (Formally HCFA) currently uses physician time in its calculation of specialty society pools in developing resource-based practice expense relative values. Ever since CMS has used physician time in its calculation of practice expense relative values, the Practice Expense Subcommittee has had the task of correcting and refining the RUC's physician time database for all codes reviewed by the RUC. Over the past two years the RUC has gone through several validation and refinement steps to standardize the various components of physician time and submitted an updated database on RUC physician time to CMS.

Doctor Robert E. Florin, MD presented to the Practice Expense Subcommittee that a set of ground rules on physician time be used to validate and standardize this data element. It is important to note that all of the ground rules Doctor Florin presented to the subcommittee had been addressed by this subcommittee in the past. The subcommittee agreed with most of Doctor Florin's proposed ground rules. Staff indicated that many of Doctor Florin's suggestions have already been included in the database. However, staff incorporated total time for the evaluation and management visits (approved by the RUC), rather than face-to-face time, as suggested in his ground rules document.

AMA staff explained that they were not aware of any specific inaccuracy in the RUC physician time database. AMA staff reminded the subcommittee that last year the subcommittee and specialty societies had gone through an extensive validation and refinement process, and the result of that work was approved by the RUC in April 2001 and submitted to CMS. The RUC then agreed that AMA staff and Doctor Florin should get together and identify any discrepancies in the data, and report back to the subcommittee at the next meeting if any additional refinements are necessary.

Post Operative Visit Data and the Practice Expense Advisory Committee (PEAC)

During the August 2001 PEAC meeting, several perceived inconsistencies in the number and level of E/M services in the global period for certain CPT codes were identified and brought to the attention of the Practice Expense Subcommittee for further review. The RUC approved a methodology for refining the CPEP data associated with 90-day global

Approved at the February 1 – 3, 2002 RUC Meeting.

period codes. This methodology applies the number and level of office visits currently listed in either the RUC or CMS databases with the standard PEAC approved E/M standard packages. This approach has been used successfully for a number of codes with global periods of 10 and 90 days. During recent meetings, the PEAC has encouraged specialties to present families of codes rather than individual codes to prevent rank order anomalies and facilitate the review of larger numbers of codes, and has therefore, increased the significance of the accuracy of both the RUC and CMS physician time databases.

During the January 2002 PEAC meeting, the PEAC again focused on refining large families of codes, and more inconsistencies in the physician time databases were identified. During the PEAC meeting, AMA staff were able to identify where the inconsistencies exist. Specifically, AMA staff identified approximately 280 codes (250 - 90 day global codes, and 30 -10 day global codes), with missing CMS post operative visit data. Within CMS's post operative visit data, each of these codes indicate a total physician time, and nothing else. In order to resolve any future inconsistencies in the RUC database post operative visit data and to assist the PEAC in its practice expense refinement, the RUC approved the following recommendation:

The subcommittee proposed that AMA staff send approximately 280 codes for which there is no CMS post operative visit data to the specialty societies to ask them to address the following issues:

1. Do you agree that the total physician time is valid?

If the answer to number 1 above is yes, the RUC asks the specialty societies to allocate the total physician time into the various time components of pre-service, intra-service, and immediate post service time periods, and include the number and level of post operative hospital and office visits.

If the answer to number 1 is no, the Practice Expense Subcommittee would provide the specialty society the opportunity to survey and bring the results before the Practice Expense Subcommittee and the RUC for approval. The survey would strictly be on physician time and would have no bearing on physician work.

During the August 2001 PEAC meeting, The American Academy of Orthopedic Surgeons (AAOS) and the PEAC identified a perceived inconsistency in a family of codes and had requested a crosswalk of post operative discharge day management time for four codes. The Practice Expense Subcommittee reviewed the family of codes and the request during its September 19th conference call, and agreed not to recommend the crosswalk at that time, but to refer the issue to the full RUC for review at the February 2002 RUC meeting. During this Practice Expense Subcommittee meeting, the subcommittee again discussed the reallocation of existing post operative discharge day management time, and the RUC approved the following recommendation:

- B. The RUC agrees that there can be one or one-half of a discharge day management code for any surgical procedure code when performed in the facility setting.**
- 3) The RUC should reallocate existing post service time to all outpatient surgical procedure codes (typically performed in an ASC or hospital outpatient department) so that one-half of a discharge day management code time element exists in the RUC physician time database.**
 - 4) The RUC should reallocate existing post service time to all inpatient surgical procedure codes so that a full discharge day management code time element exists in the RUC physician time database.**

Destruction by Neurological Agent Family – Response from Specialty Society

In the August 2001 PEAC meeting, a number of the 10-day global codes in the Destruction by Neurolytic agent family that were presented by the North American Spine Society (NASS) to have one 99212 visit assigned to the global package while other codes in the same family do not have any post-operative visits assigned. To correct this perceived inconsistency in the physician time database, the PEAC recommended that the RUC practice expense subcommittee incorporate one 99212 visit to those codes in this family that currently do not have any visits included in the global package. Only two of the codes in this family have been reviewed by the RUC: codes 64626 and 64614. The PEAC recommended that codes 62280, 62281, 62282, 64600, 64612, 64613, 64614, and 64630 each include one 99212 visit in the global package.

During the Practice Expense Subcommittee's conference call on September 19, 2001, the subcommittee reviewed its request for an additional post-operative level 2 office visit, for codes 62280, 62281, 62282, 64612, 64613, and 64614, and agreed that they were not presented with enough information to justify the change. The Subcommittee was reluctant to change physician time without sufficient survey data and full RUC review. The subcommittee requested the specialty society to write a letter explaining why each code needed an additional visit, noting that the codes may be in the same family, but may have quite different post operative care.

At this subcommittee meeting, Doctor Charles Mick, MD from NASS was given the opportunity to discuss the society's request to alter the RUC database post operative visit data for the Destruction of Neurolytic Agent family of codes. Doctor Mick presented survey results of six neurolytic injection codes with no post-operative data, and explained that the entire family of 7 codes (two of which had been through the RUC process) should have similar post operative visit care. The subcommittee discussed the data, however again believed that even though codes may be in the same family, they may have quite different post-operative care.

The RUC approved the following recommendations concerning NASS's request for changes in the post operative visit data in the RUC database:

The post operative visits data contained in the RUC database for recently RUC surveyed codes, 64614 and 64626, should not be changed.

NASS should investigate, with no objection from the RUC, changing the global periods of codes 62280, 62281, 62282, 64612, 64613, and 64614.

Lewin Report on Practice Expense Methodology – Zero Work Pool

CMS contracted with The Lewin Group (Lewin) to provide technical assistance on a variety of issues related to its Medicare Fee Schedule resource-based practice expense methodology. On June 5, 2001, Lewin issued its analysis entitled “The Resource-Based Practice Expense Methodology: An Analysis of Selected Topics”. The Lewin report specifically addresses three main areas: zero work pool, validating patient care hours, and practice expense survey of medical practices. The Practice Expense Subcommittee had a particular interest in Lewin’s discussion of the zero work pool, as CMS’s method of establishing practice expense RVUs for codes without physician work may change due to this analysis.

The procedures included in the zero work pool include technical component services and other services that presumably involve no physician time. The current approach, instituted by CMS in its November 2, 1998 final rule, establishes a separate Medicare practice expense (PE) pool for zero work services. This zero work pool was created, as an interim solution, to limit the significant reductions in the practice expense RVUs for zero work services that would have occurred under the originally proposed top-down methodology. Originally, CMS included all services with a zero work RVU (including the technical components of services with professional and technical components) in the zero work pool. However, some of the codes included were negatively impacted by the zero work pool’s methodology. CMS’s intention was not to further reduce PE payments for services in the zero work pool and it has since removed services from the zero work pool if requested to do so by the specialty that performs the service.

The Practice Expense Subcommittee discussed Lewin’s conclusions and recommendations to CMS and had some concerns about the possibility of CMS using physician work RVUs as a substitute for patient care hours. The subcommittee believed that linking physician work to practice expense would cause an inconsistency with the resource based approach, as required by statute. The RUC approved the following recommendation:

The RUC expresses concern to CMS regarding recommendation VII of the Lewin report (pages 42-43)

Carolyn Mullen from CMS stated that the initial reason for the zero work pool was to prevent a large drop in RVUs under the top down methodology, and that several specialties had requested at that time to be removed from the zero work pool. The subcommittee believed that it CMS should simulate the financial impact of Lewin’s recommendations on specialties prior to their implementation, and will look forward to the next proposed rule.

The subcommittee also discussed the process by which new codes with zero physician work are assigned practice expense relative values. The subcommittee agreed that specialties should have a chance to state whether their services should be included in this work pool methodology or not. If specialties agree that the zero work is appropriate for their code(s), they should indicate an appropriate code crosswalk, in addition to the usual practice expense inputs. In addition, the RUC approved the following recommendation:

When specialty societies present a CPT code with a zero physician work value, the cover letter should state whether the particular code and its code family for which it is contained, should be in or out of the zero work pool. If the zero work pool is appropriate, the specialty should identify what crosswalk is appropriate, in addition to the usual practice expense inputs.

**AMA/Specialty Society RVS Update Committee
Research Subcommittee Report**

Approved at the February 2002 RUC Meeting

On January 31, 2002 the Research Subcommittee met to discuss a variety of issues including the inclusion of critical care in the global surgical package and the use of IWPUR as well as other issues. The following subcommittee members were in attendance: Doctors James Hayes (chair), James Blankenship, James Borgstede, Melvin Britton, John Derr, John Mayer, Bernard Pfeifer, Don Williamson, OD, and Robert Zwolak.

Critical Care in the Global Period

The workgroup discussed the issue outlined in the June, 2001 proposed rule concerning the inclusion of critical care in the global surgical package. In that Rule, CMS questioned the appropriateness of including work relative value units related to critical care services in the post-service period of surgical codes with a 90 day global period. CMS stated that as a result of the RUC recommendations, CMS is considering future action and that this issue “will require a change in payment policy to ensure that postoperative critical care is appropriately paid.” As a result of this concern and several options outlined in the Rule, the RUC determined to review this issue. Additionally, a group of specialties comprising a critical care workgroup requested the RUC to examine this issue.

A representative of the Society of Critical Care Medicine addressed the Subcommittee to explain that as a result of the RUC including critical care services in the global package for certain surgical procedures, Medicare carriers have denied payment for critical care services provided by critical care physicians. The rationale provided by the carriers is that the global surgical package already includes payment for the critical care services and that reimbursing the critical care physician would be duplicative.

The workgroup concluded that it is appropriate for more than one physician to provide critical care services for the same patient on the same day. Additionally, in many instances this team approach is appropriate and is associated with better quality patient outcomes and should not be discouraged as a result of inappropriate payment policies. Denial of payments to critical care services should not be based on whether or not critical care services were included in the global surgical services. Therefore, several Subcommittee members felt that CMS should instruct carriers not to deny payments based on the rationale that because critical care may have been included in the global package, all other physicians should be precluded from providing critical care. The subcommittee members stated that when critical care is included in the global package, the surgeon does provide critical care services to the typical patient. However, that does not necessarily mean that the full work value for critical care services is fully reflected in the final work RVU. Rather, the inclusion of the critical care services is used as a proxy to estimate this time and work.

Doctor Paul Rudolf, CMS, stated that the issue is not a payment policy issue but rather it is a coverage policy and a medical necessity issue and he encouraged the RUC to meet with representatives of the CMS coverage group. Additionally, he stated that there is no need for any new payment policy related to this issue and the options outlined in the proposed rule were due to concerns identified by critical care specialties, not concerns on the part of CMS. Doctor Rudolf also suggested that specialty societies follow-up with carriers that are denying payment to determine specifically what is causing the denials.

Approved at the February 1 – 3, 2002 RUC Meeting.

The Subcommittee passed the following motion:

- The RUC should communicate to CMS that it does not see any evidence that a change in national Medicare payment policy is warranted. The RUC believes that none of the options mentioned by CMS in the June, 2001 Proposed Rule are appropriate or necessary. Additionally, the RUC reaffirms its support for payment for critical care by critical care physicians and denying of payment solely on the basis that critical care may have been included in a global surgical package is inappropriate.

The RUC referred the motion back to the research subcommittee to further examine the issue of inclusion of critical care services in the global period with the goal of developing a position statement that explains the policies of the RUC on this issue. This position statement could then be shared with CMS and help CMS and their carriers better interpret the RUC policies on this issue.

Use of IWPUT

Doctor Robert Florin presented the results of his research involving the use of IWPUT and the Rasch methodology. Doctor Florin explained that by using a standard RUC survey instrument, intensity measurements are obtained and then through the use of Rasch methodology, the intensity can be used as a cross check on the survey results. Previous studies conducted for general surgery and vascular surgery show a 90% correlation between survey results and the specialty's estimates of IWPUT by Rasch analysis. Doctor Florin stated that there is no evidence to demonstrate that such an analysis will work across specialties, but he stated that it is appropriate to use within families of codes. Currently, IWPUT values are calculated by backing into the number by subtracting out the pre and post service work from the total RVU. Measuring the intensity through a Rasch analysis, as well as surgical time log data, would provide a more reliable intensity measure.

The current convention of backing into IWPUT, especially when using Harvard data may produce inaccurate results. Doctor Zwolak noted that there might be several formulas for calculating IWPUTs based on total RVUs and suggested the RUC agree on a single formula for calculating IWPUTs. The Research subcommittee concluded that it would examine the various formulas for calculating IWPUT with the goal of agreeing on a single formula for calculating IWPUT.

Several workgroup members felt that the RUC should explore the use of this methodology in an effort to improve objectivity of work value determinations. Other members were concerned that while measuring intra service intensity would be beneficial, the pre and post service work would still need to be examined. The subcommittee felt that the RUC should continue to examine the use of IWPUT and the Rasch methodology as a means to supplement the primary means of determining work RVU through the RUC survey and magnitude estimation methodology.

The subcommittee passed the following motion:

- Intraservice intensity IWPUT and the Rasch analysis should be encouraged as measures of relativity between codes or in families of codes. These methods are considered adjunctive and should not be used as the sole basis for ranking or the assignment of value to a service.

The RUC referred this recommendation back to the Research Subcommittee for further study. This would allow the Subcommittee time to first develop a standard IWPUT formula and also to develop standards for specialties to use when reporting IWPUT on the summary of recommendation form.

Approved at the February 1 – 3, 2002 RUC Meeting.

RUC Practice Expense Survey

The subcommittee reviewed the RUC practice expense survey as it related to collecting data on equipment. The Subcommittee recommends changing the survey to delete questions asking for the number of units in a practice as well as the hours per week the equipment is in use for all services. The subcommittee concluded that deleting these questions would simplify the survey.

The subcommittee recommends modifying the RUC practice expense survey to delete questions on the number of units of equipment in a practice and the hours per week the equipment is in use in all services.

Update on AMA Survey Activities

Sara Thran first discussed the Patient Care Physician Survey (PCPS), the new physician survey that replaced the SMS. The 2001 PCPS was late getting started but is going very well. The Gallup Organization is the survey contractor. The PCPS has a subset of SMS questions; it is 15 minutes long, compared to the 25-minute SMS and has questions that physicians can answer fairly easily without referring to records. New questions were added on EMTALA and on-call hours.

In October 2001, 8,100 four page PCPS surveys were mailed. Gallup is attempting to complete telephone interviews with all physicians who did not complete the mail survey. So far, about 1,900 mail surveys and 700 telephone surveys have been completed. Telephone interviewing should be completed in March and the survey results should be published late this year. The goals for this project are 3,300 completed interviews and a 50% survey response rate (comparable to the 1999 SMS), and both goals are expected to be met.

Sara then discussed plans for the practice survey under development. The AMA plans to conduct the PCPS and a new practice survey in alternating years, with the first practice survey possibly in 2004. The practice survey would be a better source for practice expense information. External funding is needed for the practice survey and a number of problems uncovered in the 1999 pilot practice survey need to be resolved. Input from the RUC may be sought in refining the expense questions on the survey. Sara asked that any specialty societies contact her if they are interested in participating in pilot surveys or have a list of practices or group practices in their specialty.

ZZZ Code Definition

During the PEAC refinement of practice expense data, several specialties have proposed that a number of add on codes have separately identifiable practice expense beyond the intra-service time period. Specifically, the specialties stated that certain codes have a separately identifiable office visit in the post-service time period. Before examining these codes, the PEAC recommended that the RUC study the current definition of add on codes to determine if the definition should be changed.

The subcommittee discussed the current definition of add on codes and cited several instances where there was additional post service work as well as sometimes additional pre-service work that is currently not captured using the current definition. Some members felt that these codes may be inappropriately designated as add on codes and might be more appropriate as zero day global codes as a means to capture the additional work.

The subcommittee felt that the current definition to allow only the additional incremental intra-service work is not accurate and does not capture additional work and practice expense that may occur outside the intra-service period. The Subcommittee recommends changing the definition of

add-on codes by allowing the inclusion of work and practice expenses beyond the intra-service time period to be included.

The RUC recommends:

The RUC will request CPT and CMS to change the definition of ZZZ codes to delete the word “intra-service.” The new definition would be: ZZZ codes are reported in addition to a primary procedure and only the additional work to perform this service is included in the work RVU.

ACOG Request to Survey Incremental Work

In April, ACOG will be presenting to the RUC a series of complex hysterectomy codes and recess to utilize an incremental add-on approach for the survey process of these codes. ACOG requested to survey the base code of 5826X1 *Vaginal hysterectomy, for uteri greater than 250 grams* to establish the difference in work between the existing code 58260 *Vaginal hysterectomy, for a uterus, 250 grams or less*. Then, the increment of work assigned to the existing codes in the family would be added to the new codes for uteri greater than 250 grams. The ACOG representative stated that the only difference in work for these series of codes is the work involved in the removal of the uterus and therefore the incremental approach would lead to appropriate values for the rest of the code family. The Subcommittee agreed with this approach but also recommended that the society add questions to the survey so that respondents could indicate the percent of vaginal hysterectomies that are for uteri greater than 250 grams, both in total and for the Medicare population. This data would then be used to develop a budget neutrality adjustment for these codes.

The RUC approves ACOG’s proposal for surveying the incremental work involved in the complex hysterectomy codes.

AMA/Specialty Society RVS Update Committee

Anesthesia Workgroup

The workgroup met on January 31, 2002 to review several issues related to the five-year review of anesthesia services. The following workgroup members were present: Doctors John Mayer (chair), Norman Cohen, John Derr, Robert Florin, John Gage, Alex Hannenberg, Charles Koopman, Leonard Lichtenfeld, Sandra Reed, William Rich, and Richard Whitten.

Refinement of Anesthesia for Cataract (CPT 00142)

The workgroup first discussed a methodology for adjusting the induction period procedure building block value for code 00142, *Anesthesia for procedure on eye; lens surgery*. The workgroup reviewed the methodology originally used to develop a work value for the induction procedure. The ASA determined that a retrobulbar block is the most common type of induction procedure associated with this code, however, only half of the ASA survey respondents indicated that they provide a block when performing code 00142. The workgroup focused its efforts on determining the total percentage of time that anesthesiologists provide a block during cataract surgery and then adjust the building block value accordingly. The workgroup discussed in detail two studies that examined this issue and concluded following: 1) in about 28% of the time, an anesthesiologist provides a retrobulbar block, 2) in 2% of the time, general anesthesia is provided, and 3) in 56% of the time the anesthesiologists administers deep sedation, 4) in 14% of the time, the ophthalmologist performs topical anesthesia with monitored anesthesia care provided by an anesthesiologist.

The workgroup examined the 12 minutes allocated to this time period as well as the 7 minutes of Harvard intraservice time listed for code 67000. The workgroup reviewed in detail the elements of the service and the associated survey time of 12 minutes. After examining the time and the work involved in this time period, the workgroup concluded that the 12 minutes was too high and instead felt that an intraservice time of 8 minutes is more appropriate. The original five-year review workgroup decreased the IPP time to 6 minutes when using the typical IPP procedure of a retrobulbar block to account for the earlier estimate that half of patients that received a retrobulbar block by the ophthalmologist.

The workgroup adjusted the induction period procedure work value calculations by multiplying the 8 minutes associated with this part of the procedure by the percentage of times each type of anesthesia is provided and then multiplying by an IWPUT. The calculations are as follows:

	Time	%	IWPUT	RVU	
Retrobulbar block		8	.28	.067	= 0.1501
general anesthesia	.	8	.02	.067	= 0.0107
Deep Sedation		8	.56	.057	= 0.2554

Total work RVU for induction period procedure equals .4162

The remaining 14% applied to when the anesthesiologist did not provide any additional induction period services and therefore was omitted from the calculations of the induction period procedure.

The IWPUT value for the retrobulbar block was previously determined to be equal to general anesthesia at .067 and the workgroup agreed that the IWPUT for deep sedation should be lower

Approved at the February 1 – 3, 2002 RUC Meeting.

than the retrobulbar block and be between the IWPUT of .051 assigned for general anesthesia and .067 for the block. The workgroup felt that .057 was an appropriate IWPUT.

Finally the post induction period time was adjusted to offset the increase in IPP time to 8 minutes. After making these adjustments, 00142's building block value changed to 2.76 from the previous value of 2.77.

Several workgroup members were concerned with blending induction techniques as opposed to selecting the typical method as is done for all other RUC evaluations of physician work. However in this unique instance the workgroup concluded that it was appropriate to use the induction period time estimate, (8 minutes) determine the types of induction procedure used and then account for the percentage of time that no induction procedure is used (14%). While this methodology led to a higher building block value, the workgroup felt that this approach was more accurate than the previous methodology of just cutting the induction time by half to account for half of the time that an anesthesiologist does not perform a block.

The resulting building block RVUs for this code are attached:

Validation of the post induction period quintiles

The workgroup discussed various methods for reviewing the distribution of the time in the post-induction period. The workgroup determined that this would involve two steps. First, the workgroup would like to verify that the surgical codes that ASA selected for each of the 19 anesthesia codes are truly representative of all surgical codes that are crosswalked to the anesthesia code. This will involved examining the surgical codes associated with each of the 19 anesthesia codes and selecting the surgical codes with the highest frequency, such as the top 5 codes or at least those codes that comprise the top 25% of surgical volume assigned to the anesthesia code. A listing of these codes and their respective intra-service RUC times for each procedure will be provided to the RUC members and advisors to determine if the surgical code that ASA selected is one of the most frequently performed surgical code for that anesthesia code and also that it is representative of the surgical codes included in the ASA crosswalks.

If the workgroup concludes based on input from RUC members and advisors, that a surgical code is not representative, then the associated anesthesia code should either be removed from the analysis or the data should be changed to reflect a more appropriate surgical code.

Once the appropriateness of the surgical codes is determined, the workgroup will then ask RUC members and advisors to review the distribution of post induction anesthesia time into quintiles. This review should take place in a face to face meeting with ASA representatives present to explain the anesthesia work involved in each of the 19 codes.

The workgroup recommends that this further review of the anesthesia five year review be completed by the April RUC meeting.

**Cataract Anesthesia CPT 00142
February 2002 Workgroup Adjustments**

IPP				
	Intensity	Percent of Patients	Time	Total
RB	0.067	28%	8	0.1501
Gen	0.067	2%	8	0.0107
Deep sedation	0.057	56%	8	0.2554
			Total IPP	0.4162
			IWPUT for IPP	0.0520

PIPPA			
	Intensity	Time	RVU
Level 1	0.0224	45.8	1.0259
Level 2	0.0310	10.2	0.3162
		Total PIPPA	1.3421

Topical Anesthesia Adjustment				
	Intensity	Percent of Patients	Time	Total
Topical	0.0224	14%	8	0.0251

Total PIPPA	1.3421
Adjust for Topical	0.0251
Adjusted PIPPA	1.3672
Original WG PIPPA	1.3900
Change in PIPPA	-0.0228
New IPP	0.4162
Original IPP	0.4000
Change in IPP	0.0162
Change in Total RVU	-0.0066
Old RVU	2.7700
New Total RVU	2.7634

**AMA/Specialty Society RVS Update Committee
Valuing Services Reported with Multiple Codes Workgroup
January 31, 2001**

The Valuing Services Reported with Multiple Codes Workgroup met on Thursday, January 31, 2002 to follow up on the discussions held at their July 19, 2001 conference call (report included in Tab J of the February 2002 RUC agenda book). The following workgroup members were in attendance: Barbara Levy, MD (Chair), James Blankenship, MD, James Borgstede, MD, Melvin Britton, MD, Lee Eisenberg, MD, Emily Hill, PA-C, David Hitzeman, DO, Bill Moran, MD, Gregory Przybyski, MD, and Sheldon Taubman, MD

Presentation on Cardiology and Interventional Radiology Coding

The workgroup invited the Society of Cardiovascular and Interventional Radiology (SCVIR) and the American College of Cardiology (ACC) to present information on their component coding systems. Doctors Gary Dorfman (SCVIR) and James Blankenship (ACC) provided an overall explanation of the coding for their services. Doctor Dorfman provided the historical perspective behind the creation of their component coding system. He also explained that at the time these codes were created in CPT (pre-RUC), SCVIR conducted an extensive survey process that was validated by HCFA and CMD workgroups. Doctor Blankenship noted that although cardiology utilized component codes, many of their services are described in bundled CPT code descriptors.

The workgroup agreed that the purpose behind these presentations was to gain a better understanding of the component coding mechanisms so that the RUC may appropriately evaluate the work relative values of these services as new codes are created. The charge of the workgroup does not include any actual review of the merit of component coding versus a more bundled approach.

The workgroup also discussed potential issues related to the physician time data collected for these codes in the Harvard survey, particularly when all services reported for one episode of care are evaluated together.

Review of Utilization Data

CMS staff had offered to provide the workgroup with data on the use of radiology codes in conjunction with procedural codes, but the workgroup has not received this information to date. The workgroup will review this data, if provided, either via conference call or at the April RUC meeting. The workgroup also requested that CMS compile information on groups of services that are most typically provided and reported on the same date.

Current Methodology Utilized to Value Procedural/Imaging Services

The workgroup reviewed examples of previous recommendations submitted by interventional radiology and agreed that general guidelines should be provided to all specialties that are submitting recommendations for codes that are typically reported in conjunction with other codes. The workgroup will create a set of guidelines for review at their next conference call/meeting and will present this information to the RUC in April. The direct practice expense input rules for procedural/imaging services, developed by the American College of Radiology, are included in Tab J. These rules have been approved by the PEAC and the RUC to eliminate any duplication of direct practice expense inputs for these services when reported together.

Approved at the February 1 – 3, 2002 RUC Meeting.

**Administrative Subcommittee
February 1, 2002**

***Phoenix, Arizona
The Point at South Mountain***

Call to Order

Doctor William Gee called the meeting to order on February 1, 2002 at 8:05 a.m. The following Administrative Subcommittee members were in attendance: Doctors William Gee (Chair), Joel Bradley, Lee Eisenberg, Alexander Hannenberg, Charles Koopmann, Gregory Przybylski, Sheldon Taubman, Robert Vogelzang, Paul Wallner, Richard Whitten, and Nelda Spyres, LCSW.

I. Issue: Fax Back Ballot

As a result of the events related to September 11th and the cancellation of the RUC Meeting, the staff used a fax back ballot process to resolve time sensitive issues. The committee discussed the use of Fax Back Ballots as a useful tool in resolving issues that do not require discussion of work RVU issues or other issues that should be discussed at a face-to-face meeting.

Recommendation: The committee recommends the use of Fax Back Ballots to resolve non-work RVU issues, or other non-sensitive issues when a decision must be made between meetings.

II. Issue: Internal Medicine Rotating Seat

During the previous Administrative Subcommittee meeting, the committee agreed that the nominating sub-specialty of Internal Medicine select their nominees based on their own criteria rather than requiring board certification in the specialty area. Therefore, if the sub-specialty committee is in agreement that the selected nominee best represents the interests and expertise of that sub-specialty, then the decision of representation should be up to the sub-specialty. As a point of information, the ten Internal Medicine Subspecialties currently eligible for an Internal Medicine seat are: Endocrinology, Gastroenterology, Geriatrics, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary Medicine, Rheumatology, and Allergy and Immunology.

Recommendation: The committee reaffirmed that subspecialties deemed eligible for the Internal Medicine or other rotating seats, may choose individuals that represent the interest of the subspecialty group, and that a board certification in that particular specialty is not a requirement.

III. Issue of Openness in CPT Process

CPT allows any individuals or group to generate new code proposals. The committee discussed how codes should be addressed by the RUC in cases where the specialty societies do not adopt the responsibility of presenting codes adopted by CPT.

Recommendation: The committee agreed that codes in which there is no specialty interest in preparing a presentation to the RUC, should be presented to CMS as codes that do not have recommendations from the RUC.

Approved at the February 1 – 3, 2002 RUC Meeting.

IV. Issue of Openness in the RUC Process

While the RUC process is currently open to all individuals, many members feel that the presence of industry representatives may inhibit discussion. Some members felt that presenters should be a physician or a member of one of the specialties recognized by the HCPAC. Other members felt that as long as the specialty is in agreement that a non-RUC participant best represents the interest of the specialty societies, these individuals may assist in the presentation.

Recommendation: The committee affirmed that the specialty society should decide whether industry representatives or other non-RUC participants assist in their presentation. Guests of the specialty society or the chair should be required to wear a special color nametag to indicate that the person is a guest.

V. Issue of Conflict of Interest and Financial Disclosure

At the October 6, 2000 Administrative Subcommittee Meeting, the RUC approved an annual review of the Statement of Compliance and Conflict of Interest Policy. During the review of these documents, the committee recommended no changes in either form. Due to the infrequent instances of financial interest, these forms should not be included in the agenda book, unless there is an interest to disclose.

Recommendation: The committee recommends that the Statement of Compliance will remain the same and RUC members will be required to sign these forms annually. The Conflict of Interest Policy will remain the same. However, Financial Disclosure forms will not be included in the agenda book unless financial disclosure is necessary.

VI. New Member CVs

The information provided by new members is too detailed. The committee discussed condensed formats to present new member's biographical information to the RUC.

Recommendation: The committee recommends that new members submit a one page biographical sketch of their CV. Staff will draft a template that will highlight contact information and background experiences related to socioeconomic issues.

VII. The RUC 10-Year Anniversary

Due to the events of September 11th, the 10-year anniversary dinner was cancelled. The committee discussed a commemorative dinner to replace the previously cancelled 10-year anniversary dinner.

Recommendation: The Committee recommended that the staff plan a formal Black-tie event for the September 2002 meeting.

**AMA/Specialty Society RVS Update Committee
Conscious Sedation Workgroup
February 2, 2002**

The following members of the Conscious Sedation Workgroup met on Saturday, February 2, 2002: Doctors William Gee (Chair), James Blankenship, Norm Cohen, John Derr, Lee Eisenberg, Lanny Garvar, Steve Krug, Alan Plummer, Robert Vogelzang, Maurits Wiersema, and Eileen Sullivan-Marx, PhD, RN. The workgroup continued their discussions regarding conscious sedation from their July 11, 2001 and August 1, 2001 conference calls. These conference call reports are included in Tab L in the February RUC agenda book.

The workgroup reaffirmed its recommendation to the RUC that the general approach should be to retain the conscious sedation as bundled into the procedure code only where it is an inherent part of the service. The workgroup agreed that it would like to receive consensus from the RUC members before moving forward with any work related to this approach. The rationale for the recommendation is contained in the conference call reports.

The RUC recommends the following:

- 3. The general approach to the conscious sedation issue should be to retain the conscious sedation as bundled into the procedure code only where it is an inherent part of the service.**
- 4. Separate reporting and payment of conscious sedation codes 99141 and 99142 should be allowed when conscious sedation is not inherently included as a component of the physician work of the procedure code.**

Identification Process to Determine Which Codes Inherently Include Conscious Sedation

The workgroup understands that there are approximately 30 codes that have been reviewed by the RUC where either the vignette or the description of work specifically indicates that conscious sedation is an inherent part of the service. In addition, several CPT codes, either reviewed by CPEP or the PEAC, indicate specific supplies related to conscious sedation that may provide some information regarding which codes currently include conscious sedation.

The workgroup agreed that this information could serve as one source of code identification. In addition, it will be necessary to solicit specialty societies to provide a list of codes in which conscious sedation is an inherent component and a list of codes where conscious sedation may be utilized. The workgroup would then review a compilation of both lists at the April 2002 RUC meeting.

The RUC recommends that an identification process initiate to determine which codes inherently include conscious sedation and which codes may sometimes require conscious sedation.

Future Steps

The workgroup agreed that the issues related to relative value evaluation and changes to CPT descriptors should be discussed after the specific lists as discussed above are developed.

Approved at the February 1 – 3, 2002 RUC Meeting.

March 19, 2002

Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Scully:

The AMA/Specialty Society RVS Update Committee (RUC) recently reviewed the definition of codes with a global period of *ZZZ* and a recommendation contained in the CMS sponsored study of the resource-based practice expense methodology. I am forwarding the RUC recommendations on these two issues.

CMS Definition of the *ZZZ* Global Period

During the current practice expense refinement process, a number of specialty societies questioned the definition of codes with *ZZZ* global periods, commonly referred to as add-on codes. Since these codes by definition are always performed in conjunction with another code and are never performed independently, the RUC has consistently followed the CMS definition of add on codes to only value the incremental intra-service work required to perform the service. Any pre-service or post-service work associated with the code has never been included in the work value of the procedure.

Several specialties have stated that with certain add on codes, there is separately identifiable post-service work associated with the service. For example, an add on code describing a suture of an additional nerve may lead to a separately identifiable office visit that is not currently captured in the global package of the base code. Therefore, the additional practice expense and physician work associated with the additional office visit in the post-operative period is not recognized. The RUC concluded that the current definition to allow only the additional incremental intra-service work is not accurate and does not capture additional work and practice expense that may occur outside the intra-service period. The RUC recommends changing the definition of add-on codes by allowing the inclusion of work and practice expenses beyond the intra-service time period to be included in the development of relative values.

The RUC therefore requests CMS to change the definition of *ZZZ* codes to delete the word "intra-service" from the current definition so that the definition would become: *ZZZ* codes are reported in addition to a primary procedure and only the additional work to perform this service is included in the work RVU.

Lewin Report on Practice Expense Methodology - Zero Work Pool

On June 5, 2001, The Lewin Group, Inc. issued its report to CMS and the CPT Editorial Panel entitled "The Resource-Based Practice Expense Methodology: An Analysis of Selected Topics". The Lewin report addresses three main areas: the zero work pool, validating patient care hours, and practice expense survey of medical practices. The RUC discussed Lewin's conclusions and recommendations concerning the zero work pool. Specifically, the report contained a recommendation for CMS to change its methodology by using physician work RVUs as a substitute for patient care hours. Currently, the CMS practice expense methodology uses patient care hours to develop practice expense per hour values, which are then used to create the practice expense specialty pools and the practice expense relative value units. While CMS has not indicated whether it plans on implementing Lewin's recommendation, the RUC concluded that substituting physician work for patient care hours would change CMS's practice expense methodology in such a way that it would no longer recognize all of the resources necessary to provide physician services. This would cause an inconsistency with the resource-based approach, as required by statute, and therefore the RUC requests CMS not to implement this particular recommendation.

Thank you for your consideration of these comments. If you have any specific questions regarding our relative value recommendations, please contact Patrick Gallagher at the AMA at (312) 464-4738 or via e-mail at patrick_gallagher@ama-assn.org.

Sincerely,

James G. Hoehn, MD

cc: Tracy Gordy, MD
Paul Rudolf, MD
Ken Simon, MD
RUC Participants