

**AMA/Specialty RVS Update Committee
Meeting Minutes
January 30 – February 1, 2003**

I. Welcome and Call to Order

Doctor James G. Hoehn called the meeting to order on Thursday, January 30, 2003 at 8:15 am. The following RUC Members were in attendance:

James G. Hoehn, MD, Chair	James D. Maloney, MD*
James Blankenship, MD	David L. McCaffree, MD
Dale Blasier, MD*	Bill Moran, MD
James P. Borgstede, MD	Bernard Pfeifer, MD
Melvin C. Britton, MD	Gregory Przybylski, MD
Neil H. Brooks, MD	Sandra B. Reed, MD*
Norman A. Cohen, MD*	William Rich, MD
James Denny, MD*	Peter Sawchuk, MD*
John Derr, Jr. MD	Chester W. Schmidt, Jr. MD
Lee D. Eisenberg, MD	J. Baldwin Smith, III, MD
John O. Gage, MD	Peter Smith, MD*
William Gee, MD	Holly Stanley, MD*
Meghan Gerety, MD	Susan M. Strate, MD
Alexander Hannenberg, MD	Trexler Topping, MD*
David F. Hitzeman, DO	Arthur Traugott, MD*
Charles F. Koopmann, Jr., MD	Richard H. Tuck, MD
M. Douglas Leahy, MD*	James C. Waldorf, MD*
Barbara Levy, MD	Paul E. Wallner, DO
J. Leonard Lichtenfeld, MD	Richard W. Whitten, MD
Charles D. Mabry, MD*	Don E. Williamson, OD

*Alternate

II. Chair's Report

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

- Doctor Hoehn thanked RUC Members and staff for the kind expressions of concern and well wishes that were sent to his wife during her recent illness.
- Doctor Hoehn congratulated Doctor William Rich on his appointment by the AMA Board of Trustees as RUC Chair. He will assume his responsibilities at the conclusion of the April RUC Meeting.
- Doctor Hoehn recognized Doctor Greg Przybylski for his recent comments to the national media discussing issues within Professional Liability Insurance. His comments have been published in the *New York Times* and the *Washington Post* as well as mentioned by President Bush in a speech delivered to various health care professionals in Scranton, Pennsylvania.

- Doctor John Gage has been elected the Secretary of the American College of Surgeons.
- Doctor Charles Mabry has been elected to the Board of Regents of the American College of Surgeons.
- Doctor James Hayes, American College of Emergency Medicine has resigned from the RUC.
- Doctor Hoehn welcomed two new RUC Members:
 - Susan M. Strate, MD, FCAP, College of American Pathologists
 - Michael D. Bishop, MD, American College of Emergency Physicians
- Doctor Hoehn announced that this is Doctor Alexander Hannenberg's last meeting as a RUC member representing the American Society of Anesthesiologists (ASA). He will become the Alternate ASA RUC member and Doctor Norman Cohen will become the new ASA RUC member at the April RUC Meeting.
- Doctor Hoehn thanked the Administrative Subcommittee and AMA Staff for their hard work in making the 10-Year Anniversary of the RUC a success. An article within the *AMA News* featuring this historic event has been e-mailed to all RUC members.
- Doctor Hoehn briefed the RUC on a meeting which was held on November 13th, 2002, that was requested by Tom Sully, the Administrator of the Centers for Medicare and Medicaid Services (CMS). Mr. Tom Grissom, Mr. Scully, and other CMS representatives, meet with Doctors Hoehn, Hannenberg, Whitten, Mr. Patrick Gallagher, and Ms Sherry Smith.
- The purpose of the meeting was to receive clarification regarding the recommendations made by the RUC during the Five-Year Review of the anesthesia codes.
- During the November 13th meeting, Doctor Hoehn invited Mr. Scully and his staff to attend a future RUC meeting. Mr. Scully has indicated that he will attend the April 2003 RUC Meeting. The details of his visit will be announced.
- Doctor Hoehn announced that the Conflict of Interest Forms will be circulated for signature in Spring 2003.
- Doctor Hoehn introduced the following visitors:
 - William Schroeder, American Association for Vascular Surgery
 - Members from Rehabilitation Engineering and Assistive Technology Society of North America
 - Pam West, Centers for Medicare and Medicaid Services
- Doctor Hoehn announced the members of the facilitation committees:

Committee I

Mohs Micrographic Surgery (Friday 7 - 8 am)

Richard H. Tuck, MD (Chair)
Melvin C. Britton, MD
Charles F. Koopmann, Jr., MD
John E. Mayer, Jr., MD

Bernard Pfeifer, MD
J. Baldwin Smith, III, MD
Paul E. Wallner, DO
Richard W. Whitten, MD

Committee II

Meghan Gerety, MD (Chair)
Michael Bishop, MD
William Gee, MD
J. Leonard Lichtenfeld, MD
Alexander Hannenberg, MD
David F. Hitzeman, DO
Gregory Przybylski, MD
Chester W. Schmidt, Jr., MD

Committee III

Barbara Levy, MD (Chair)
James Blankenship, MD
James P. Borgstede, MD
Neil H. Brooks, MD
John Derr, Jr., MD
John O. Gage, MD
David L. McCaffree, MD
Susan M. Strate, MD

III. Director's Report

Sherry Smith made the following announcements:

- Several of the February 2003 RUC Agenda CDs that were sent to RUC members were encoded incorrectly during production. Staff sent revised CDs to RUC members. Revised CDs and other handouts are available through AMA Staff.
- Suggestions are now being taken for the location for the February 2004 RUC meeting. Please make your suggestions to AMA Staff.
- The RUC database will be sent to RUC members after the February 2003 Meeting.
- Jane Carlile, Staff to the College of American Pathologists, will be retiring from the College and this will be her last RUC meeting. Ms. Carlile has participated in the RUC process since its formation in 1991.

IV. Approval of the Minutes for the September 27 – 29, 2002 RUC Meeting

- Doctor Whitten gave staff editorial revisions that will be incorporated into the minutes.

The amended minutes were accepted.

V. CPT Update

Dr. Lee Eisenberg briefed the RUC on the following issues:

- The CPT Editorial Panel will be reviewing 75 items at its February 2003 Meeting, which should directly affect the agenda of the RUC's April 2003 Meeting.
- CPT Process for E/M Coding and Documentation Guidelines- The Clinical Examples Task Force has met several times via teleconference call to discuss issues pertaining to the creation of clinical examples for the E/M codes including the validation of these examples. Task Force members were asked to look at 90 vignettes for different levels of E/M codes for various specialties. They were then asked to assign an E/M code for each of the clinical examples. The result of this exercise showed various levels of agreement from the nine

members. The Clinical Examples Task Force members will be meeting face-to-face in the upcoming months to discuss this exercise and to determine the characteristics of a template clinical example including the length of the clinical example and the information that should be included. The template clinical example would ultimately be sent to specialty societies to be used as a tool in the creation of their own clinical examples. Doctor Eisenberg will report on the progress of the Workgroup at the April RUC Meeting

Several RUC members on the Clinical Examples Task Force met informally to discuss the validation process of these clinical examples. The RUC members voiced concern that the methods of validation that the RUC currently employs may not work well in validating the cross-specialty work equivalency of these clinical examples.

Doctor Sawchuck, a representative on the Task Force for CPT, indicated that the full RUC should be included in reviewing any instructional materials as the RUC would be responsible for reviewing the specialty feedback to these instructions. He therefore made the following motion:

Prior to the specialty societies being asked to develop clinical examples, the content and format of the template clinical examples and instructions should be presented to and approved by the RUC at a face-to-face meeting.

The RUC discussed this motion and the general implications of this project. A RUC member asked specialties represented at the meeting whether their societies continued to hear complaints regarding the current E/M guidelines. Several RUC members indicated that this was not a major issue within their specialty. The RUC agreed that input by the CPT Editorial Panel and the RUC was important prior to distribution of the instructions

This motion is approved.

VI. CMS Update

Doctor Rudolf briefed the RUC on the following issues:

- The Final Physician Rule was published on December 31, 2002. In addition, errors in the values, globals or policy indicators will be corrected and published in a Technical Correction Notice.
- The Physicians Professional Advisory Committee (PPAC) Meeting will take place on February 10, 2003. The discussion will include what items should be addressed in the 2003 Spring Proposed Rule.
- Revisions to the Teaching Physician Guidelines have been released. Several conference calls with representatives of the Association of American Medical Colleges (AAMC) took place to clarify and revise the guidelines.

- The Proposed Rule for ASCs was published in June 1998. It is in the process of being finalized and will be published in Spring 2003. There are roughly 300 codes that have been added or amended to the ASC list. The payment methodology has not been changed and this issue will be addressed in the next Final Rule.
- Several RUC members questioned the measures that CMS is employing to survey access issues. Doctor Rudolf responded that this issue has been brought to PPAC and as a result when beneficiaries call in with complaints, they are asked several questions related to access issues. In addition, there is a yearly CMS survey to collect various data from beneficiaries. A section has been added to this survey targeting access issues. The survey results will be published in Winter 2003 or Spring 2004 and will be presented to PPAC at the Spring 2004 Meeting. In addition, there is now an entire section of CMS dedicated to this issue which has a published strategy for monitoring access. Also, at the Physician Open Door Forum governed by Rueben King-Shaw, Deputy Administrator to CMS, physicians were asked to identify those areas where access is a problem.
- Rolling Five-Year Review:
Patrick Gallagher stated that AMA Staff has received questions from a few RUC members regarding CMS's position on a rolling Five-Year Review and asked CMS to explain its current intentions regarding the Five-Year Review. Doctor Rudolf responded that CMS in the past has requested for the flexibility of bringing codes to the RUC for consideration before or after a Five-Year Review process. CMS has stated that if they identified a particular code for consideration outside the Five-Year Review process, the specialty should have the opportunity to also bring the code's family for consideration to the RUC to avoid rank-order anomalies. CMS has not recommended or agreed to a rolling five-year review and has no plans to implement in the future. Doctor Rudolf did note that legislation required CMS to conduct this review at least every five years. If specialties or the RUC wished to shorten this time period to three or four years, they could propose this to CMS who would consider the request.

Several RUC members expressed concern about the rank order anomalies created when a particular code is brought for consideration to the Five-Year Review and its family is not considered. Doctor Rudolf responded that CMS has received requests by specialty societies between Five-Year Reviews to have codes reviewed by the RUC because they felt these codes were undervalued. CMS's response is that these codes have been examined and that unless these codes were directly affected by changes in a code brought by CMS for RUC review, the review of these codes could be deferred until the next Five-Year Review. Sherry Smith announced that the next Five-Year Review process would commence on November 1, 2004 when CMS calls for comments in its Final Rule. The following motion was made following this discussion that the RUC Administrative Subcommittee should consider a potential request to decrease the increment of time between the refinement processes.

The Administrative Subcommittee should consider the time and resources necessary to conduct these reviews; the logistical impact of these reviews on all RUC participants; and appropriateness of conducting more frequent reviews.

This motion was accepted by the RUC.

- The RUC thanked CMS for its kind and appreciative acknowledgement of the RUC and PEAC process, as well their the compliments to the specialty society and AMA staff.

VII. Washington Update

Sharon McIlrath reviewed several legislative and regulatory issues:

- The CMS Final Rule was released December 31, 2002. There were several positive aspects to the Final Rule including a change to the productivity factor, a factor that estimates the increases in practice costs. This change will add an estimated \$15 billion dollars back into Medicare over the next ten years. The AMA will continue to work on other issues related to the conversion factor and will be presenting it at the next PPAC testimony on February 10th. The AMA continues to advocate that drug costs not be included in the expenditures and that CMS include the costs of regulations and policy changes in the SGR
- Ms. McIlrath provided the RUC with the recent legislative history regarding organized medicine's efforts to fix the negative update of -4.4% set to go into effect on March 1, 2003. The AMA has argued that CMS could fix the CMS mistakes regarding enrollment projects, etc., which would result in a 1.6% increase in 2003. CMS has determined that it needs congressional approval to make these corrections. The AMA is pursuing this action, as well as a strategy to "freeze" the payments at the 2002 level where congress would invoke the Congressional Review Act to disapprove the December 31, 2002 Final Rule.

Staff Note:

On February 20, 2003, President Bush signed into law the Conference Report on the Omnibus Appropriations package (H. J. Res. 2) which gave CMS the authority to make the corrections. The 4.4% conversion factor decrease has been diverted and replaced with a 1.6% increase.

- Medicare Reform- President Bush laid out his plan for Medicare reform in the President's State of the Union Address. He proposed dedicating \$400 billion over the next 10 years to Medicare reforms and creating a drug benefit.
- Professional Liability Insurance Reforms: President Bush has been very supportive of PLI reform and has made a number of public remarks recently, including in a speech in Scranton, PA, where he mentioned Dr. Przybylski, the RUC member for neurosurgery.
- Antitrust and regulation relief, uninsured, mental health parity, bioterrorism, patient safety, physician-pharmaceutical relations and economic credentialing

are all issues currently being addressed by the AMA and Ms. McIlrath offered to discuss these issues in more detail with any RUC members who were interested.

- Ms. McIlrath responded to a number of questions addressed by RUC members, including:
 - The current efforts being made by the AMA about the requirement for translators and the EMTALA issue. Ms. McIlrath stated that she is unsure about the status of EMTALA. She addressed the translator issue by stating that the AMA has continued to write letters stating its position that it is important that the physician and the patient communicate, however, you can not ask physicians to pay more for an interpreter than they are going to get paid for the visit. The Final EMTALA Rule will be published in the late Spring or early Summer 2003.
 - The deadlines for claims processing to get the 2002 Medicare Fee Schedule rate. Ms. McIlrath stated that for the services performed during the first two months of 2003, these services will eventually be paid at the 2002 Medicare Fee Schedule rate. If the claim for a service is processed before March 1, 2003, this claim will be processed with the 2002 rate. Any claim that is not processed before March 1, 2003, the claim will be processed with 2003 rate no matter when the service was provided however, for these claims a mass adjustment will occur in July to re-adjust the January and February services to the 2002 rate.
 - The payment system for the voluntary smallpox vaccine and the professional liability associated with administering the vaccine. Medical insurers said they would not cover patients who voluntarily took the Smallpox vaccine and got complications because they were taking it as a part of their job and it was a Workman's Compensation issue. The Workman's compensation groups stated they would not cover the cost because it was a voluntary program and they do not cover voluntary issues. Ms. McIlrath stated that AMA is aware of these issues and has been working with the Administration to solve them.
 - The AMA's position on National Coverage Decisions and the AMA's position on coverage decisions that actually reduce overall program expenditures. Ms. McIlrath stated that as long as CMS is reflecting all of the coverage decisions that would increase overall program expenditures then, the AMA would not be able to argue coverage decision that would reduce expenditures. The AMA is concerned that even if there was a separate price increase put in the SGR component for the prescription drugs, there is concern that next year there will be a reduction in AWP.

VIII. Relative Value Recommendations – Requests from CMS

Central Venous Nervous System Assessments/Tests (Tab 4)

James Georgoulakis, PhD, American Psychological Association, and Nelda Spyrès, LCSW, National Association of Social Workers

After much discussion about the Central Nervous System Assessments/Tests (CPT codes 96100, 96105, 96110, 96111, 96115 and 96117), it was determined that there was a lack of communication and participation between the interested physician and non-physician participants who perform these services. After discussion of this issue, it was determined that no physician specialty societies are interested in formally presenting codes 96100, 96105, 96115, and 96117. Therefore, the following motion was made: **The four identified services (96100, 96105, 96115 and 96117) will be referred to HCPAC.**

This motion was adopted.

In addition, there was discussion of the two remaining codes (96110 and 96111). It became unclear which specialty societies were interested in participating in the evaluation of these codes. Due to this confusion, Doctor Brooks made the following motion- **The two identified codes that contain physician work will be sent to AMA staff to determine the interested specialty societies and prior to the April RUC Meeting a determination will be made with these specialty societies about the future review of these codes.**

Staff Note: The American Academy of Pediatrics will take the lead in presenting these codes at the April 2003 RUC Meeting.

This motion was adopted.

IX. Relative Value Recommendations for CPT 2003

Laparoscopic Hysterectomy/Myomectomy Procedures (Tab 5)

George Hill, MD, FACOG and Sandra Reed, MD, FACOG, American College of Obstetricians and Gynecologists

Interim Recommendation from April 2002 Meeting:

New codes 58545, 58546, 58550, and 58552-58554 were created to specifically describe vaginal hysterectomy/myomectomy procedures performed on enlarged uteri.

At the April 2002 meeting, the specialty society stated that they would need to re-survey these codes, as the correct global period for these services should be 90 days not 10 days as stated on their survey instrument. The specialty society presented survey data at the February 2003 RUC meeting. In the interim, the RUC

recommended that these laproscopic codes be valued equivalent to the recommended relative work values of the open approach hysterectomy codes as follows:

New Code	Tracking Number	Crosswalk to Code	Work RVU (Interim 2003)
58545	BA1	58140	14.60
58546	BA2	58146	19.00
58550	BA3	58550 (old code number 56308)	14.19 (no change)
58552	BA4	58550 (old code number 56308)	14.19
58553	BA5	58290	19.00
58554	BA6	58290	19.00

58550 and 58552 both compared to 58550 *Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)* (RVU = 14.19) because there is no difference in the work of removing the tube or ovaries in the laproscopic approach. The same applies to 58553 and 58554 where both are crosswalked to 58290 *Vaginal hysterectomy, for uteri greater than 250 grams* (recommended RVU 19.00). Therefore, the RUC recommended interim 2003 work relative values of 14.60 for 58545, 19.00 for 58546, 14.19 for 58550 and 58552, 19.00 for 58553 and 58554.

RUC Recommendations from the February 2003 Meeting:

At the February 2003 meeting, the specialty society presented survey data for all 6 codes. For all codes, the specialty society determined that a 090-day global period should be used for the survey. The RUC expressed concern that the pre-service time of 90 minutes for all six of these procedures is too high and suggested that it be reduced to 60 minutes to be consistent with other major surgical procedures. The specialty society agreed to modify its recommendation of pre-service time to 60 minutes for all six codes. The RUC also discussed the issue of work neutrality for these codes, as the new codes are derived from existing services. The RUC agreed with the specialty that the new codes described new techniques that were not previously performed under the existing codes. In addition, these services would not likely be provided to Medicare patients.

New CPT Codes 58545 *Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas* and 58546, *Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams* replace deleted CPT code 58551 *Laparoscopy, surgical; with removal of leiomyomata (single or multiple)* (work value = 14.21). Old CPT code 58551 was previously assigned a global of 010, while the new CPT codes are assigned a 090 day global. The specialty society had presented a median survey result of 14.86 and an IWP

comparison to reference code 58140 *Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach* (14.60 RVU). However, the RUC did not agree that the work described in 58545 differed than the work described in the existing code, 58551 (14.21). The RUC recommends the 25th percentile of the survey median of 14.21. **The RUC recommends work relative values of 14.21 for code 58545.**

The RUC had previously recommended an interim value of 19.00 for new CPT code 58546, utilizing 58146 *Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach* (work value = 19.00) as a crosswalk. The specialty society then conducted a survey, which also resulted in a survey median of 19.00. The specialty society's survey indicated more intra-service time for the laparoscopic approach (180 vs. 150 minutes), but a lower amount of hospital visit time (30 vs. 79 minutes). The RUC agreed that the open approach remained an appropriate crosswalk and recommends 19.00 for 58546. The specialty clarified that the post-surgical office visits should be revised from one 99214 visit and one 99212 visit to two 99213 visits. The RUC's comments on the work neutrality above apply to this service. It was also noted that the services now described by 58546 had previously been performed as open procedures, under code 58146. **The RUC recommends a work relative value of 19.00 for code 58546.**

Existing CPT code 58550 was modified and three new codes (58552, 58553, and 58554) were created to specifically differentiate between laparoscopic hysterectomies performed with or without removal of tube(s) and/or ovary(s) and to differentiate based on size of the uteri. CPT code 58550 will now specifically states that it is reported for laparoscopic vaginal hysterectomies only, for uteri less than 250 grams. The RUC understands that this is how this code was originally evaluated when it was added to CPT in 2003. At that time, the work value for this code was determined by comparing the code to CPT 58260 *Vaginal hysterectomy* which did not include the removal of tube(s), and/or ovary(s). The specialty surveyed thirty-six physicians and a consensus panel of physicians to determine the final recommendations for code 58550. For code 58550, a work relative value of 14.19 reflected the 25th percentile of survey responses. The validity of the 25th percentile value was tested using IWPUT analysis. The specialty society determined that the resulting IWPUT of .08 was an appropriate value for this procedure since the laparoscopic route for hysterectomies is chosen over the vaginal route due to some factor impeding the vaginal route. The RUC agreed that the work relative value for this service should not change for its current value of 14.19. **The RUC recommends a work relative value of 14.19 for CPT code 58550.**

CPT code 58552 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)* now describes the services in which the tube(s) and/or ovary(s) are also removed. The work relative value survey median for this service was 16.00. The validity of the median value was checked using IWPUT analysis that resulted in an IWPUT of .07, which the specialty society

concluded was appropriate. In addition, the society used a building block approach to validate the recommendation and to identify the appropriate value for removal of tubes and ovary(s). The increment between the laparoscopic hysterectomy only procedure described by 58550 and the hysterectomy with removal of the tube(s) and/or ovaries, described by 58552, was 1.81 RVUs. In comparison to the traditional procedure codes CPT code 58260, *Vaginal hysterectomy* (RVU = 12.98), and CPT code 58262, *Vaginal hysterectomy; with removal of tube(s), and/or ovary(s)* (RVU =14.77) the increment of 1.79 RVUs, is a very similar increment. In addition, when comparing the surveyed code (58550) with similar codes 58150, *Total abdominal hysterectomy*, and CPT code 58260, *Vaginal hysterectomy*, the specialty felt that the relative value recommendation was consistent with other hysterectomy codes. The RUC agreed that the increment and the overall relativity was correct and recommends the survey median of 16.00. **The RUC recommends a work relative value of 16.00 for CPT code 58552.**

New CPT code 58553, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; without removal of tube(s) and/or ovary(s)*, and code 58554, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)*, were created to reflect new techniques allowing surgeons to remove larger uteri laparoscopically. The specialty society stated that there is additional work with the more complex procedures thereby necessitating the new codes. For code 58553, the specialty society analyzed data received from thirty-one surveys and tested the validity of the median surveyed RVW using IWPUT analysis. The specialty society determined that an IWPUT of 0.08 was an appropriate value for the level of service for these codes. The specialty society also compared the surveyed code 58553 with similar codes 58150, *Total abdominal hysterectomy* and 58290, *Vaginal hysterectomy, for uterus greater than 250 grams*. CPT code 58150 is valued at 15.24 RVW and the RUC approved 19.00 RVW for 58290 at the April 2002 meeting. The RUC agreed with the survey median, which indicated that the median value for code 58553 was 20.00, a value slightly larger than 58290 due to the increased work for removing larger uteri laparoscopically. The specialty modified the post-service visits from one 99214 and one 99212 to two 99213 visits. **The RUC recommends work relative values of 20.00 for CPT code 58553.**

Analysis of the survey results for new CPT code 58554 indicated median of 22.00 RVUs. The specialty society tested the validity of the survey results using IWPUT analysis and found an IWPUT of 0.09. The 0.09 intensity was slightly higher than for 58553. The specialty agreed that complexity and physician skill required of this procedure should result in a greater intensity, and therefore determined it to be appropriate. The specialty compared the difference in similar vaginal procedures CPT code 58260 *Vaginal hysterectomy* (12.98 RVUs) and CPT code 58262, *Vaginal hysterectomy with removal of tubes and ovary(s)* (14.77 RVU). The difference in the work increment between these two codes is 1.79 RVUs. In comparison, the difference in the recommended values for the laparoscopic codes 58553 and 58554 is 2.00 RVUs. The RUC agreed that this increment and the overall relativity for this code was

appropriate and recommends the survey median of 22.00. **The RUC recommends work relative values of 22.00 for CPT code 58554.**

Practice Expense

The RUC approved the practice expense inputs for 58545, 58546, 58550, and 58552-58554. The RUC understood that the 090- day global period standard should apply for all of these codes. The revised practice expense sheets are attached to this recommendation. **The RUC recommends all the practice expense inputs presented by the specialty society.**

Mohs Micrographic Surgery (Tab 6)

John A. Zitelli, MD, American College of Mohs Micrographic Surgery and Cutaneous Oncology and Brett Coldiron, MD, American Academy of Dermatology Association

RUC Recommendation from April 2002:

For CPT 2003, the American Academy of Dermatology recommended changes that would clarify that a biopsy and frozen pathology could be done on the same day as Mohs surgery. In addition, the specialty proposed changes to special procedures such as decalcification of the bone during Mohs surgery or specialty stains (i.e. immunostaining for melanoma). Finally, modifications to code 17310 were recommended to clarify that each specimen after the first 5 specimens in each layer is separately reimbursable. The Center's for Medicare and Medicaid recommended that the work value for 17310 be changed from 000 to ZZZ. CPT approved these changes.

Modification to codes 17304, 17305, 17306, and 17307 were considered editorial changes, and were not reviewed by the RUC. The specialty survey for code 17310 did not provide calculations that were work neutral. In addition, RUC members were unclear on the historical information regarding whether the code could be billed more than one time on the same day for greater than 5 specimens, as the interpretation from CPT differed from the interpretation put forth by CMS in 1994 letter from a CMS Chief Medical Officer. Therefore, the RUC approved a motion to let the value stand for the CPT 2003 cycle as interim. Between the April 2002 RUC Meeting and the February 2003 RUC Meeting, an ad-hoc committee would further clarify with CPT the intent of code 17310. In addition, the specialty society would revise their survey based on the agreed upon interpretation of the descriptor and the new ZZZ global period.

The RUC recommends an interim work relative value for CPT code 17310 of 0.95.

Practice Expense

The RUC referred practice expense inputs for this family of codes to the September 2002 Practice Expense Advisory Committee.

RUC Recommendation from February 2003:

A workgroup of the RUC reviewed this issue at the February 2003 meeting and concluded that a number of issues should be addressed regarding these services, including:

- The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion, rather than the number of specimens. The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated.
- In the interim, the RUC recommends that CMS retain the 2002 work relative value of 0.95 for CPT code 17310. In the December 31, 2002 *Final Rule*, CMS had published that it had reduced the RUC's interim recommendation of 0.95 to 0.62. CMS concluded that intent of the code had changed as it will now be described as an add-on code. The RUC believes that CMS should research its past policies regarding this code, as the specialty has provided documentation that CMS had already been under the assumption that this service was an add-on and could be reported once for each additional specimen beyond the first five specimens. Specifically, the specialty has referred to the November 25, 1991 *Final Rule*, which states that "Code 17310, which is described as *Mohs', more than 5 specimens, fixed or fresh tissue, any stage*, should be treated as a single specimen; that is, if more than 5 specimens are necessary at any stage, each additional specimen beyond 5 should be separately paid. The work RVUs have been established according to the above interpretation." The RUC is also concerned that CMS' approach to determining a new value of 0.62 may be flawed. CMS only considered the pathology work and the specialty has presented that the work of the additional excision should also be factored into the work relative value.
- The RUC's Practice Expense Advisory Committee had reviewed the direct practice expense inputs for these services in April 1999. The RUC recommends that these recommendations remain "interim" pending re-definition and re-evaluation of this family of codes.
- The workgroup that extensively examined this issue at the February 2003 meeting will be assigned to review this issue again after the codes are re-defined by CPT.

X. Relative Value Recommendations for CPT 2004

**Anesthesia Services: Mediastinoscopy and Diagnostic Thoracoscopy (Tab 7)
Karl Becker, M.D., and James D. Grant, MD, American Society of
Anesthesiologists**

CPT revised existing code 00528 and created a new CPT code 0052X to differentiate between utilizing one lung ventilation and not utilizing one lung ventilation for anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy. When single lung ventilation is used for diagnostic thoracoscopy and surgical thoracoscopy the anesthesia procedure is more complex, therefore, a new code was created to describe the procedure using one lung ventilation. Technical advances have allowed for an increasing use of one-lung ventilation, therefore a new code was needed.

00528

Because the anesthesia codes are valued using a different system utilizing base units and time, the RUC concluded that the best way to determine the proper base units for these codes is to compare the recommended values to other anesthesia codes to determine if the relativity. The RUC could not value the code in any other manner such as a comparison to non-anesthesia codes since the base units contain physician work, practice expense and PLI and are used with time units as well. For CPT code 00528 *mediastinoscopy and diagnostic thoracoscopy not utilizing one lung ventilation*, the specialty recommended that the base unit remain at a value of 8 base units. In comparison to the reference code 00540 *Anesthesia for thoracoscopy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* (base unit 12), the RUC felt that the recommended value of base units was appropriate given the differences in work between the two codes and also in comparison to the recommended value of 11 base units for the new code 0052X *mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation*. The RUC also reviewed other anesthesia codes with base units of 8 to ensure that the recommended value for CPT code 00528 is appropriate. In addition, ASA stated that the vast majority of the coding for 00528 are for mediastinoscopy and not the more difficult diagnostic thoracoscopy. Therefore the base units should not change due to the coding revisions that specify the diagnostic thoracoscopy not utilizing one lung ventilation.

The RUC recommends a base unit of 8 for code 00528.

0052X

The recommended base units for the new code 0052X *Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation* was reviewed primarily in comparison to code 00528. The RUC also compared the recommended value to the reference service CPT code 00541

Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation (base unit 15). Also the code was compared to CPT code 00210 *Anesthesia for intracranial procedures; not otherwise specified* (base unit 11). The RUC concluded that the recommended value was appropriate as it reflected the additional work of utilizing one lung ventilation in comparison to CPT code 00528.

The RUC recommends a base unit of 11 for code 0052X.

Anesthesia for External Cephalic Version Procedure (Tab 8)

Karl Becker, M.D., and James D. Grant, MD, American Society of Anesthesiologists

CPT created new code 0196X *Anesthesia for external cephalic version procedure* due to an increase over the past few years in the demand for anesthesia services for pregnant women with babies presenting in a breech position. Recent studies have shown that the success rate is enhanced by the woman having adequate analgesia. Typically, unsuccessful external cephalic versions go on to a planned cesarean delivery. If the external cephalic version procedure is successful, a vaginal delivery occurs at a later date.

The RUC compared the new code primarily to the reference code 01960 *Anesthesia for vaginal delivery only* (base unit = 5) and concluded that the anesthesia work was similar with these two codes. The RUC also examined other anesthesia codes to determine proper rank order codes such as 00635 *Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture* (base unit = 4), which involves less work than code 0196X. Primarily the intensity and risk of the new code 0196X is greater due to increase risk of fetal compromise as a result of the moving of the baby. Also code 01916 *Anesthesia for diagnostic arteriography/venography* (base unit = 5) was compared and determined to have similar physician work.

The RUC recommends a base unit of 5 for code 0196X

Hyoid Myotomy and Suspension (Tab 9)

James Denny, III and Samuel Mickelson, MD, American Academy of Otolaryngology – Head and Neck Surgery

The RUC reviewed the survey results for Hyoid Myotomy and Suspension code 217X1 during its meeting in February 2003. The RUC was concerned that the specialty used a lengthy vignette which included a detailed description of the procedure that may have biased the survey results. The RUC referred the code back to the specialty society for revision of the vignette and new survey. The issue will be reviewed by the RUC in April 2003.

Soft Tumor Excision (Tab 10)

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

Six new CPT codes were created and one code was revised excision (codes 210X1 – 210X3, 2290, and 229X1 – 229X3) to complete the family of codes for subcutaneous and deep soft tissue. After discussion, the RUC identified several issues to be addressed. First, the RUC was in agreement in the existence of three major groups within the family of lesion excision codes including biopsy, excisions, and radical excisions. As with other excision codes, soft tumor codes should be similarly structured to include a description of margins of the lesions. Second, the RUC was concerned that the vignettes were incongruent with the rationale. Third, it was determined that not all of the specialties affected by these codes were included in the survey process. Therefore, the RUC determined that this issue should be postponed until a more complete package of these, and additional codes, could be presented by the specialties that perform soft tumor excision. Doctor Gage made the following motion: **These codes should be referred back to CPT for restructuring.**

This motion was passed.

Staff Note: The CPT Editorial Panel accepted the request to rescind “excision of soft tissue tumor” codes, the revision of code 22900, and the addition of the associated references for these codes in anticipation of receipt of a more extensive multi-specialty society proposal to reflect a consistent approach to excision of soft tissue tumors in multiple anatomical locations throughout the Surgery section of CPT for inclusion in CPT 2005.

Lateral and Extracavitary Technique Vertebral Corpectomy and Arthrodesis (Tab 11)

Presenters: John Wilson, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons and Charles Mick, MD, North American Spine Society

The CPT Editorial Panel created six new codes: 225X1, 225X2, 225X3, 630X1, 630X2 and 630X3 to describe the lateral extracavitary approach when performing vertebral corpectomy and arthrodesis. The current codes do not capture the operative technique and work involved with performing these procedures with a lateral extracavitary approach.

225X1

The RUC examined code 225X1 *Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic*. It was determined by the RUC after reviewing the reference code 22556 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic*; (RVU 23.46) that the intra-

service time of the new code (intra-service time=170 minutes) is similar to the intra- and post-service time of the reference code (intra-service time=180 minutes). However, the new code had a higher pre-service time. The RUC agreed that a significant amount of pre-time is necessary as the patient positioning is more extensive, and the pre-service evaluation time is longer as these are typically older patients with more medical co-morbidities. In addition, the intra-service period of the new code was deemed more intense than the reference code. Therefore, the RUC agreed with the specialty society that the 25th percentile RVW for 225X1, as it reflects the appropriate comparison to 22556. **The RUC recommends a work relative value of 24.00 for 225X1.**

225X2

The RUC examined code 225X2 *Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar*. It was determined by the RUC after reviewing the reference code 22558 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar*; (RVU=22.28) that the new code and the reference code both had 180 minutes of intra-service time and similar post-service time. However, the new code has higher pre-service time. The RUC agreed that a significant amount of pre-time is necessary as the patient positioning is more extensive, and the pre-service evaluation time is longer as these are typically older patients with more medical co-morbidities. In addition, the intra-service period of the new code was deemed more intense than the reference code. Therefore, the RUC agreed with the specialty society that the 25th percentile RVW for 225X2, as it reflects the appropriate comparison to 22558. **The RUC recommends a work relative value of 23.12 for 225X2.**

225X3

The RUC examined code 225X3 *Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional interspace (List separately in addition to code for primary procedure)*. It was determined by the RUC after reviewing the reference code 22585 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (RVU=5.53) that the intra-service time of the new code (60 minutes) was higher than the intra-service time of the reference code (45 minutes). In addition, the new code was deemed more intense and required additional technical skill and effort when compared to the reference code. Therefore, the RUC agreed with the specialty society that the increased time and intensity required to perform this procedure support the specialty society's median value of their survey (work RVU = 6.00), which was minimally higher than the relative work value associated with the reference code (RVU = 5.53). **The RUC recommends a work relative value of 6.00 for 225X3.**

630X1 and 630X2

The RUC examined codes 630X1 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retracted bone fragments); thoracic, single segment* and 630X2 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retracted bone fragments); lumbar, single segment*. The majority of the respondents who perform this procedure indicated that the key reference service code should be CPT code 63087 *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single*; (RVU=35.57). It was determined by the RUC after reviewing the reference code that the intra-service time of the new code (215 minutes) was less than the intra-service time of the reference code (265 minutes). However, the new code was deemed more intense than the reference code. Therefore, the RUC agreed with the specialty society that the median survey RVW (32.00) is recommended for 630X1 and 630X2. This recommendation is less than the work value of the reference code and fairly balances the slightly higher intensity intra-service component with lower intra-service time. **The RUC recommends a work relative value of 32.00 for 630X1 and 630X2.**

630X3

The RUC examined code 630X3 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retracted bone fragments); thoracic or lumbar, each additional level (List separately in addition to code for primary procedure)*. The majority of the respondents who perform this procedure indicated that the key reference service code should be CPT code 63088 *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)*. (RVU=4.33). It was determined by the RUC that the intra-service time of the new code (60 minutes) was less than the intra-service time of the reference code (67 minutes). However, the new code was consistently identified as being more intense and requiring additional technical skill/effort when compared to the reference code. This rationale supports the higher work value reflected in the median survey result compared with the reference service. **The RUC recommends the survey median RVW of 5.00 for 630X3.**

Practice Expense

The practice expense for 225X1, 225X2, 630X1 and 630X2 follows the PEAC accepted neurosurgery complex spine procedures packages. There are no practice expense inputs requested for 225X3 and 630X3, as these are add-on codes. The practice expense recommendations presented by the specialty society were accepted by the RUC.

Transbronchial Biopsy Procedures (Tab 12)

American College of Chest Physicians/American Thoracic Society

Due to the variability in the survey responses, the specialty society requested that they resurvey and present this family of codes at the April 2003 RUC Meeting.

Naso- or Oro-Gastric Tube Placement (Tab 13)

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

A new code for CPT 2001, 43752, *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* was added to CPT for naso- or oro-gastric tube placement by a physician (e.g. requiring additional skill or involving additional risk). Three new cross-references were also added: 1) to differentiate between enteric and oro-gastric tube placement (44500, 74340); 2) to direct the user to imaging guidance (76000); and 3) to instruct the user in the appropriate use of this code in conjunction with critical care and neonatal intensive care services.

CMS then reviewed the code and believed that the code should include fluoroscopic guidance. In August 2002, the CPT Editorial Panel revised code 43752 for its 2003 cycle to include fluoroscopic guidance, and image documentation and report. For the 2003 Medicare Fee Schedule, CMS created code G0272 *Naso/oro gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* (Work RVU = 0.32) for one year until an identical CPT code becomes effective.

In February 2003, the RUC reviewed the specialty society's survey results for CPT Code 43752 carefully in conjunction with relative physician work of the following procedures:

44500 *Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)* (Work RVU = 0.49)

74340 *Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation* (Work RVU = 0.54)

76000 *Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)* (Work RVU = 0.17)

91105 *Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons)* (Work RVU = 0.37)

The RUC understood that the typical patient for CPT code 43752 was one for which there had been multiple failed attempts by hospital staff to establish the tube placement. The RUC compared CPT code 43752 to CPT code 44500 and 74340 as fluoroscopy is separately reported when performing 44500. A combined work value of 1.03 is computed for this service, as compared to the recommended work RVU of 0.82 for 43752. The RUC also agreed that CPT code 43752 compared favorably with common complex E&M services. The RUC disagreed with CMS's current valuation of the physician work for the code, and believed the specialty society's

survey results reflected the true physician work involved. **The RUC recommends a relative work value for code 43752 of 0.82.**

Practice Expense

This service is only provided in a facility setting, therefore, the RUC has not recommended any practice expense inputs for this code.

Limited Temporal Lobe Resection and Lobectomy (Tab 14)

Alan Plummer, MD, FCCP, American Thoracic Society, and Scott Manaker, MD, PhD, FCCP, American College of Chest Physicians

The specialty societies involved requested more time to collect additional surveys for these codes. They will present the data on these services at the April 2003 RUC meeting.

Amniotic Membrane Transplant (Tab 15)

Stephen Kamenetzky, MD, Trexler Topping, MD, and David Glasser, MD American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgery

The CPT Editorial Panel created four new CPT codes to describe amniotic membrane transplantation. These are relatively rare procedures, which will be provided to Medicare patients less than 500 times per year. Ophthalmology conducted a survey and presented its recommendations, based on the survey data and review of a consensus panel. The RUC agreed that the recommendations presented by ophthalmology were appropriate, in comparison to reference services as described below.

657X1 Ocular surface reconstruction; amniotic membrane transplantation: The survey time for 657X1 was 60 minutes pre-time, 60 minutes intra-time, and 185 minutes total post-time. The pre-and post-time was greater than key reference service *65750 Keratoplasty (corneal transplant); penetrating (in aphakia)* (work RVU = 15.00) with pre-time of 40 minutes and total post-time of 158 minutes. However, the intra-service time for 657X1 was 60 minutes, versus 90 minutes for 65750. The RUC agreed with the specialty that the 25th percentile of the surveyed work value of 10.25 was a more appropriate representation of the work, as the intra-service period is 1/3 less time and the respondents viewed intensities of these two services as comparable. **The RUC recommends a work relative value of 10.25 for CPT code 657X1.**

657X2 Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor): The survey time for 657X2 was 60 minutes pre-time, 90 minutes intra-time, and 193 minutes post-time, compared to the time for 65750 (40 minutes pre-, 90 minutes intra-, and 158 minutes post). The RUC agreed that the intensity of 657X2 is greater than 65750 and noted the greater pre-, and post-time for the new service. The RUC also compared this service across specialties to CPT code 44120 *Enterectomy, resection of small intestine; single resection and anastomosis* (work

RVU = 17.00), with intra-service time of 90 minutes and comparable pre- and post-time. The RUC agreed with the specialty society's recommendation of 17.67, which is slightly less than the survey median. **The RUC recommends a work relative value of 17.67 for CPT code 657X2.**

657X3 Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft): The survey time for 657X3 is nearly identical to the time for 65760 (60 minutes pre-time, 83 minutes intra-time, and 178 post-time), and the specialty presented that the intensity of this new service is higher than the reference service. The RUC also reviewed services performed by other specialties, such as 43610 *Excision, local; ulcer or benign tumor of stomach* (work RVU = 14.60) and 35266 *Repair blood vessel with graft other than vein; upper extremity* (work RVU = 14.91) with comparable intra-service times and agreed that the service was appropriately valued across specialties. The RUC agreed that the survey median, as presented by the specialty society was appropriate. **The RUC recommends a work relative value of 15.00 for CPT code 657X3.**

657X4 Harvesting conjunctival allograft, living donor: The RUC compared the survey data and time for this new service (pre-time of 30 minutes, intra-time of 20 minutes, and post-time of 95 minutes) to two reference codes 65870 *Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechia, except goniosynechia* (work RVU = 6.27, pre-time = 20 minutes, intra-time = 33 minutes; and post-time = 106 minutes) and 65855 *Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)* (work rvu = 3.85, pre-time = 15, intra-time = 15, and post-time = 55). The RUC agreed that the 25% of the survey was appropriate at 4.90 work values. **The RUC recommends a work relative value of 4.90 for CPT code 657X4.**

Practice Expense:

The RUC accepted the specialty society's recommended direct practice expense inputs, which were based on the PEAC standards for pre-time and post-procedure visits. These procedures are all performed in a facility setting.

Intraoperative MRI (Tab 16)

American Association of Neurological Surgeons/Congress of Neurological Surgeons

In a letter to the RUC, the specialty society requested to present the proposal on the April RUC meeting to allow a more accurate and complete survey of the physicians who perform this procedure.

Ophthalmic Ultrasound (Tab 17)

**David Glasser, MD, Stephen Kamenetzky, MD, and Trexler Topping, MD,
American Academy of Ophthalmology**

Ophthalmology had initially requested that the CPT Editorial Panel create an editorial revision to CPT code 76512 to describe it as ophthalmic ultrasound, echography, diagnostic; contact B-scan only. However, CPT decided to make this revision and create a new code that would be utilized when an A-scan and a B-scan were performed at the same time. Ophthalmology had a difficult time collecting survey data for this new CPT code, as this is typically only done in the University setting. The RUC agreed that an interim value for the new CPT code 7651X *Ophthalmic ultrasound, echography, diagnostic; contact B-scan and quantitative A-scan* should be cross-walked from existing CPT code 76511 *Ophthalmic ultrasound, echography, diagnostic; A-scan with amplitude quantification* (work RVU = 0.94) until a survey could be completed. *Note: At the February 7-8, 2003 CPT Editorial Panel meeting, this coding action was rescinded. There will be no changes to these codes in CPT 2004 as CPT has requested that the specialty work on a coding revision for CPT 2005.*

Comprehensive Coagulation Assessments (Tab 18)

Cheryl Hirsh-Ginsberg, MD, College of American Pathologists

CPT created a new code 8542X (*Coagulation/fibrinolysis assay, whole blood (eg. thromboelastography), interpretation and report*) to describe a relatively uncommon service that is performed to assess the integrity of the hemostatic system in a patient with a significant bleeding problem. The code is used during procedures such as liver transplant, cardiac services, and in the ICU. It was predicted that due to the reporting requirements, anesthesia would not be a large provider of this service and would be used mostly by pathology. In the future, however, it is likely that utilization of this service will increase as its utility is appreciated and more physicians become comfortable with interpretation.

The RUC discussed in detail the possibility of billing multiple times for this code and determined that the value should be based on a single coagulation episode. Discussion with the presenters indicated that each interpretation performed in a series requires review of the previous tests, increasing the work proportionally. This mitigates the concern about declining pre-service work when the test is performed multiple times. The number of times the test can be performed and billed is of concern, but the RUC deemed this issue as primarily a payment policy issue, not a valuation issue. Decisions about multiple tests may be required in a given patient and should be based on medical necessity. The RUC believes that review of utilization may be required prior to setting any limitations on use. The RUC does not recommend adding additional language in CPT to limit the use of the codes.

The RUC compared the code to two reference codes, 88180 (*Flow cytometry; each cell surface, cytoplasmic or nuclear marker* work RVU, 0.36, physician total time of

25 minutes) and CPT code 85390 (*Fibrinolysins or coagulopathy screen, interpretation and report* work RVU 0.37, physician total time of 35 minutes). The RUC agreed that the ASA surveyed time totaling 35 minutes should be used in spite of the low response rate. The committee felt that the comparison of work with code 85390 is equivalent given the same total time estimates and an examination of work involved. The committee agreed that the value of 0.37 is appropriate and accurately captures the work involved in this procedure.

The RUC recommends a work RVU of 0.37 for code 8542X.

Practice Expense

There are no direct inputs for this code.

Refilling and Maintenance of Implantable Pump (Tab 19)

Karl E. Becker, MD, American Society of Anesthesiology, and Eduardo Fraifeld, MD, American Academy of Pain Medicine

September 2002 RUC Recommendation

In November 2001, CPT created a new code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular)*. Although some providers were reporting this service with CPT code 96530, *Refilling and maintenance of an implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)*, the specialty indicated that this code was inappropriately utilized. The physician services that are described by CPT code 95990 should have been previously reported using code 64999, *Unlisted procedure, nervous system*. Code 95990 describes a service requiring direct physician involvement and therefore, the service should have an assigned work value. The RUC clarified with the presenters that the physician and a registered nurse typically provide the service together. With this in mind, the RUC recommended that code 95990 include an editorial note to indicate that the physician is always present during the performance of this service.

A coalition of several specialties, including pain medicine, anesthesiology, neurosurgery, and spine surgery reviewed and surveyed the new CPT code 95990. A survey median of 1.82 was collected from 67 physicians, who indicated a pre-service time of 10 minutes, an intra-service time of 20 minutes, and a post-service time of 7 minutes. After the review of survey responses, the societies felt that the median survey value (1.82) was too high, therefore, the specialty society recommended 1.38, which is between the 25th percentile (1.11) and the median. The RUC did not agree that a work RVU of 1.38 was appropriate.

Although this code is billed often with an E/M code, the RUC understood that the survey respondents were surveyed for the specific work of the service only. The group identified relatively similar services for which they could compare work, time, and intensity. The RUC focused its comparison on two codes, 67500 *Retrolubar*

injection; medication (separate procedure, does not include supply of medication) (Work RVU = 0.79) and *62252 Reprogramming of programmable cerebrospinal shunt* (Work RVU = 0.74). The RUC surveyed the physician time for the 62252 is 15 minutes pre-service time, 20 minutes intra-service time, and 10 minutes post-service time. This was comparable to the time for 95990 and the RUC agreed that 62252 serves as a good cross comparison to this new code. **The RUC recommended the work RVU of 0.77 for CPT code 95990.**

February 2003 RUC Recommendation

In November 2002, CPT created the new code 959XX to specifically indicate administration by a physician or administration under the direct supervision of a physician. Since the creation of the new code clarified the role of the physician, the RUC agreed with the specialty societies that the work value for CPT code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);*, should be changed to 0.00 work RVUs. The RUC also agreed that, for CPT code 9599X, *administered by physician or under direct supervision of physician*, the previous RUC recommendation for 95990 of 0.77 work RVU, should be crosswalked to code 9599X. **The RUC recommends a work relative value for CPT code 95990 of 0.00 and a work relative value of 0.77 for CPT code 9599X.**

Practice Expense

The practice expense inputs for code 95990 and 9599X are the same and these inputs were approved at the April 2002 RUC meeting.

XI. Practice Expense Advisory Committee (PEAC) Update (Tab 20)

The Practice Expense Advisory Committee met prior to the RUC in January 2003 and Doctor Moran brought the members up to date on the PEAC's activities from its last two meetings. Doctor Moran briefly highlighted the actions from the PEAC's September 2002 meeting where the PEAC finalized pre-service time recommendations for 090 day global period codes, made pre-service time recommendations for specific 000 and 010 day codes, established a cleaning endoscope workgroup, and recognized additional time for stomas. In addition, Doctor Moran explained that the PEAC will be concentrating on the refinement of these 000 and 010 day codes at the beginning of this year, and that at its most recent meeting the PEAC reviewed almost 500 codes.

Doctor Moran pointed out that the methods of dealing with practice expense at the PEAC and those when dealing with practice expense at the RUC is not quite the same. Doctor Moran's concern is that for future codes going through the RUC process, the same scrutiny currently being applied at the PEAC should be applied going forward at the RUC, so that all codes are evaluated equally. It was suggested that the RUC at least think about how the RUC could transition from a group

focused on physician work, to one focused on both physician work and practice expense. Carolyn Mullen from CMS agreed with his perception and suggestions and added that new codes for which the RUC has made practice expense recommendations aside from the PEAC, should still be open for full PEAC review.

XII. RUC HCPAC Review Board Report (Tab 21)

Don Williamson, OD, presented the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board Report. Dr. Williamson announced the two new members of the RUC HCPAC Review Board: Robert Fifer, PhD, representing the American Speech Hearing and Language Association and Bernard Pfeifer, MD, the RUC representative from the American Academy of Orthopaedic Surgeons. Dr. Williamson informed the RUC that the Review Board has approved the revised RUC HCPAC Structure and Functions and the HCPAC codes submitted to the September PEAC meeting. Dr. Williamson indicated that the relative value recommendations for CPT 2004 Rehabilitation Assessment and Integration Service (97537 and 977XX) have been deferred to the April RUC HCPAC Review Board meeting. Doctor Williamson announced that nominations for the RUC HCPAC Co-Chair will be discussed at the April RUC HCPAC Review Board Meeting. The new Co-Chair will assume his/her position at the September RUC HCPAC Meeting

The full report of the RUC HCPAC Review Board is attached to the minutes.

XIII. Zero Work Pool Workgroup Report (Tab 22)

Doctor Britton presented the report of the zero work pool workgroup. Doctor Britton explained that the zero work pool was created due to a defect in the top down methodology and was needed to prevent a drastic cut on the PE RVUs. Due to the variety of practice arrangements by providers of these services, the original SMS data may have underestimated the PE/hr figures. CMS created this alternative to the standard methodology as a temporary measure for codes representing about \$8 billion in annual Medicare charges. The committee will continue to examine the methodology and has asked specialties to identify any data requests for CMS that could be examined in time for the next RUC meeting. In particular the committee would like CMS to walk through an example for a code using a numerical example to show how the PE/hr figure, the scaling factors, and the zero work pool methodology affects a particular code. Such an example would help the committee better understand this complex methodology. The committee will continue to gain a better understanding of the issue and determine what role, if any, the RUC should have in making a recommendation to CMS regarding their use of the methodology. The RUC accepted the Workgroup report without discussion.

XIV. Practice Expense Subcommittee Report (Tab 23)

At the February 2002 RUC meeting, AMA staff identified 227 non-RUC surveyed 010 and 090 day global CPT codes which have only total time within CMS's

database. The PEAC assigns post operative practice expense inputs according to existing codes through RUC and CMS physician time components. These 227 CPT codes apparently were cross-walked by CMS in some unknown manner. Since these codes did not have any time components used for practice expense purposes, only total time, the RUC has asked specialty societies to provide time allocations under specific guidelines. In an effort to decrease the administrative burden of this task on the specialties, the Practice Expense Subcommittee and the RUC made the following recommendations:

For this exercise, the RUC accepts a methodology for reducing CMS total physician time for those codes for which a specialty society who predominately performs the service, believes it is appropriate, by accepting a cross-walk to a similar family of codes that have RUC surveyed times, and/or may use an expert panel.

The RUC then reviewed 26 physician time allocation recommendations recommended by the subcommittee and submitted by the American Association of Oral & Maxillofacial Surgeons/American Dental Association and made the following recommendation.

The RUC accepts the survey results submitted by the specialties for these 26 codes (21026-21070 and 40800-40831)

The RUC members expressed their concern once again that the physician time recommendations from this exercise are to be “administrative” for practice expense purposes only and have no bearing on physician work. The RUC recommended that these codes’ data are: **clearly identified within the database as not being allowed to be considered when making work recommendations. This would apply not only for the physician time components from the surveys, but other information contained on the summary of the recommendation forms (ie, the vignette and descriptors of work), would state “DO NOT USE TO VALIDATE FOR PHYSICIAN WORK”.**

For this RUC meeting, AMA staff found that there are a number of codes in the RUC database with surveyed physician time in which a work relative value was not approved by the RUC. These codes were entered into the database when physician time was not deemed an important determinate of physician work. AMA staff had currently identified 85 codes in the RUC database where the RUC rationale states that the work value is recommended to be maintained. The RUC believed that these codes are no less reliable than all the other codes approved by the RUC during this very important time period. The RUC recommends that:

The RUC data for these 85 codes identified by AMA staff should be grandfathered and retained in the RUC database. These codes will be identified in the RUC database as “Surveyed Physician Time has Not been Validated by the RUC”.

Earlier, the RUC recommended administratively, for practice expense purposes, the RUC should allocate a full discharge day management code to those inpatient services and a half a discharge day management time to outpatient or ASC codes as determined by Medicare utilization data, with the caveat that specialty societies may look at their codes to determine place of service and tell the RUC, particularly those for which Medicare volume is lacking where they fit. This would not change the total physician time in the database, as this is an administrative change that will be noted in the database.

During the most recent PEAC meeting, the PEAC addressed an alternative proposal. The PEAC proposed that the discharge day management time should be assigned in the facility setting. The amount of time allocated should be based on whether the procedure is predominately performed on an in-patient or out-patient basis. The subcommittee and the RUC agreed with the PEAC's proposal and made the following recommendation:

Allocate 6 minutes of clinical staff time for discharge management for out-of-office locations; unless there is CMS/RUC data (or specialty society input) to indicate that it is most commonly performed as an inpatient procedure. If there is data to support that a procedure is most commonly performed as inpatient, allocate 12 minutes of clinical staff time for discharge management.

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

XV. Administrative Subcommittee Report (Tab 24)

Doctor Gee presented the Administrative Subcommittee report on Saturday, February 1, 2003. The RUC discussed the Structure and Functions document, RUC and PEAC rotating seat elections, joint RUC member and staff lunches, possible locations for the January/February 2004 RUC Meeting, a recognition dinner for Doctor Hoehn, RUC Member attendance at CPT meetings, and review of vignettes prior to review by the RUC.

- **RUC Structure and Functions**

Regarding the last criterion, Doctor Dickey of the Endocrine Society stated that he felt that the phrase "as determined by the RUC" was unclear, and should be removed if it could not be clarified. Doctor Meghan Gerety stated that she felt the language was "squishy" and also would support removing the criteria. In addition, she felt that the input from other societies not meeting these criteria is vital and suggested that one solution to obtaining broader input would be to expand the number of rotating seats. Other discussion participants suggested that AMA Counsel review the newly added phrase. The committee unanimously accepted the following motion:

The RUC recommends revising criterion number five of the Structure and Function document to state “The specialty is not meaningfully represented by an umbrella organization, as determined by the RUC.”

- **Rotating Seat Elections**

A few alternate balloting methods were proposed by RUC members; however, Doctor Gee explained that those methods were previously reviewed by the Subcommittee and determine less effective.

In paragraph 2 of the Rotating Seat Election section, Doctor Wallner pointed out that, as written, the current language implies that a subspecialty interested in a rotating seat would need only to petition to be placed on the list. He suggested that the language in the report be modified to reflect that a specialty must petition, “and be approved as eligible by the RUC.”

On voter eligibility, Dr. Britton questioned who would be eligible to vote. Doctor Hoehn stated that all current members of the RUC with voting seats are eligible to vote.

The issue of eligible ballots was also discussed by the RUC. Doctor Borgstede questioned whether in the case of three or more candidates each RUC member has to vote for three candidates in order for the ballot to be eligible. As a solution, Doctor Hoehn proposed that names be placed on the ballot to ensure that staff could return the invalid ballot to the voter. A RUC member argued that ballots should remain confidential and proposed the following motion:

The RUC should use unidentified ballots.

A majority of the RUC members speaking on the resolution agreed identification on the ballot would reduce the likelihood of invalid ballots. The motion was defeated.

Regarding the issue of ties, Doctor Przybylski pointed out that the report did not include a method for dealing with a tie. As there could be infinite possibilities for dealing with ties, the group did not decide upon one single method, however, Doctor Gee offered that there were several methods that could be used in the case of an unbreakable tie.

Paragraph 4 of the report states that a majority is defined as 50 percent plus one vote. Doctor Sawchuck questioned what exactly constitutes 50 percent plus one vote. Doctor Hoehn clarified that there must be a quorum to hold the election and the majority is considered 50 percent plus one vote of the total number of valid ballots cast. This clarification will be added to the definition of the majority.

The RUC discussed when the election would be held. It was determined that the election would be on Saturday morning so that all candidates would be able to attend the election.

For the election of rotating seats, the Administrative Subcommittee recommends that the RUC adopt the guidelines that are in the Administrative Subcommittee report, as well as other modifications to the report as agreed.

The RUC accepted the guidelines as modified.

- **PEAC Rotating Seats**

Doctor Gee clarified that if there are any candidates for the rotating seat, there will be an election, as those holding the existing seats are currently serving under extended terms. Any candidates participating in the election must meet the eligibility criteria in order to participate in the election.

- **Possible Locations for the January/February 2004 RUC Meeting**

The site of the January/February 2004 RUC meeting has not yet been selected. Doctor Gee requested that the RUC direct comments regarding the location to the AMA staff.

- **Recognition Dinner**

Regarding the date of Doctor Hoehn's Recognition Dinner, Doctor Gerety proposed Friday, April 25, 2003 and many of the members agreed that Friday would be better accommodate more RUC members. Staff will work with Doctor Gee on the details of the dinner.

- **Other Issues**

Doctor Hoehn reminded the committee that the RUC decided that a RUC member would attend future CPT Meetings. Doctor Hoehn asked RUC members to express their interest in participating in CPT meetings to Sherry Smith. The meeting following the February 2003 CPT meeting is being held in Los Angeles, May 1-4th, 2003.

CPT Vignettes were discussed by the RUC and Doctor Eisenberg volunteered to review vignettes prior to the meeting to identify issues that may be problematic for the RUC to review the issue. Also staff requested that that specialty societies submit their survey materials to the RUC prior to sending them out for the survey process.

The Administrative Subcommittee Report was accepted by the RUC as modified above.

XVI. Research Subcommittee Report (Tab 25)

Doctor Borgstede presented the report of the Research Subcommittee. The Research Subcommittee recommended that a reformatted RUC survey instrument be allowed for use in surveying families of codes. The specialty societies would determine if they wanted to use the reformatted survey and would group codes into a family as determined by the specialty. When a specialty presents its recommendation to the RUC, they would need to explain their methodology and their rationale for grouping codes into a family. There was a discussion whether specialties would first need to notify the RUC of using the reformatted survey. The RUC decided that notifying the RUC and obtaining approval would delay the process and present an onerous burden on specialties. The RUC agreed that specialties would be in the best position to define the code families and it is in the specialty's own best interest to make sure that codes are grouped into cohesive families. The subcommittee concluded that developing a generic definition of code families at this time is not possible, and therefore it will be up to the individual specialties to explain to the RUC their rationale for grouping codes. If the RUC does not agree with the rationale the specialty runs the risk of having their proposal rejected and would need to represent to the RUC at another meeting.

The RUC accepted the Subcommittee's recommendation:

The RUC endorses the reformatted RUC survey instrument for use in surveying families of codes.

Doctor Borgstede asked specialties to provide any comments on the Central Venous Access vignettes to CPT staff prior to the CPT meeting next week. The RUC did not take any action on this issue.

The Subcommittee examined the RUC methodology for calculating time and intensity measurements and during the discussions it became clear that specialties have been using a variety of methods for calculating these measurements. The Subcommittee decided to explicitly state how to calculate these measurements and the RUC approved the following Subcommittee recommendation without any discussion:

For the new and revised codes, calculate physician time based on all responses, but calculate intensity data only from those responses that chose the reference code listed on the summary of recommendation form. In addition, the number of respondents that chose the reference service listed on the summary form should be provided on the summary form.

The Subcommittee discussed how specialty societies should be able to use recommendations developed by an expert panel to either substitute for survey data or to support survey data. The RUC discussed in detail whether a RUC survey is always required, and whether a panel can be used instead of a survey. Some RUC members felt that a specialty should be allowed to use a panel instead of a survey without ever having to attempt a survey. Other RUC members felt that the RUC needs to explicitly state that specialties should conduct a survey and that the survey remains the primary source of data. While this is stated in the current RUC instructions several RUC members felt it needed to be restated in the body of the recommendation. The RUC discussed whether a panel process could be used instead of a survey or could only be used after a survey was attempted and the specialty determined that the survey failed or the results were unreliable. The most frequently cited example was when an insufficient number of responses was received. The RUC concluded that a survey must be attempted and if the survey data is determined to be unreliable, then a panel can be used. It is the responsibility of the specialty society to describe the survey process, explain why the results should not be used, and provide the survey results. RUC members stressed that the RUC should be able to review the survey data, even if the specialty considers the results flawed. This would prevent a specialty from not using survey results only because the specialty determined the survey results produced an RVU that was too low and the panel was used to develop a higher recommendation. Therefore by providing the survey results the RUC makes the final determination whether the survey was flawed. Prior RUC approval to use a panel would not be required, but the RUC stressed that specialties would need to convince the RUC that developing a RUC recommendation through a panel process is justified.

The RUC approved that the following recommendation be added to the RUC survey instructions:

The survey remains the primary source of information to value physician work for codes submitted to the RUC. Expert panel methodology may be submitted if a specialty society determines that the survey may be flawed or needs to be supplemented. A specialty society that chooses to use an expert panel as its primary source of developing a work relative value recommendation it must present the survey data and their rational for using the expert panel.

The subcommittee discussed possibly using blended data rather than valuing codes based on a typical patient. The subcommittee felt that development of new CPT codes would be a better alternative if it felt there were distinct patient populations that would warrant the creation of new codes. The RUC accepted without discussion the subcommittee recommendation to make no changes in current RUC methodological standard pertaining to the typical patient.

The Research Subcommittee Report was approved and its appended to these minutes.

XVII. Conscious Sedation Workgroup Report (Tab 26)

Doctor William Gee, Chairman of the Conscious Sedation Workgroup provided the RUC with an update on the conscious sedation project. He stated that the Workgroup intends to finalize a coding proposal on this issue at the April 2003 meeting, which will include a list of codes where conscious sedation is inherent to the procedure and the suggested revision to the current conscious sedation stand alone code family. This proposal will be reviewed by the RUC in April. It is anticipated that any recommendations to the CPT Editorial Panel would be considered in the CPT 2005 cycle.

The Workgroup also recommends that an update on this project be included in the RUC comment letter to CMS to initiate a dialogue on the issue. In particular, the Workgroup would be interested in learning whether CMS has any questions or concerns regarding the list that will be discussed and finalized in April. The RUC and CPT effort on this issue is to initiate a policy change where CMS will begin separate payment for conscious sedation for those services that do not inherently include conscious sedation. It is important to understand any CMS suggestions or concerns regarding this effort prior to the conclusion of the Workgroup's recommendations.

The Conscious Sedation Workgroup Report was approved and is attached to these minutes.

XVIII. RUC Comment Letter on the 2003 Medicare Physician Payment Schedule Final Rule (Tab 27)

Ms. Smith introduced a draft RUC comment letter on the Final Rule for the 2003 Medicare Physician Payment Schedule, published in the December 31, 2002 *Federal Register*. She indicated that this draft was included for discussion purposes and a second draft would be circulated in mid-February. The comment period will close on March 3, 2003.

The RUC discussed a section of the comment letter regarding the Five-Year Review of Anesthesia work and determined that, as drafted, this section did not reflect the recommendations of the RUC on this issue. This section will be re-drafted and reviewed by the RUC members by mid-February.

XIX. Other Issues

- Regarding materials that are presented to the RUC, the RUC agreed that all language used to identify specific physicians or patients should be removed from distributed materials.

- To facilitate RUC discussion and understanding of anesthesia issues, the RUC recommended that AMA staff include anesthesia base units in succeeding versions of the database.
- Increasingly, seated RUC members are providing more comments related to their own specialty society's presentations. Doctor Whitten requested a more careful and judicious consideration of the effect that these comments may have on the issue under consideration by the RUC.
- Doctor Gee indicated that the current practice expense methodology is causing a distortion in procedures that are carried out in hospitals and offices, by creating improper incentives for performing procedures in the facility setting. Doctor Hoehn recommended that this issue be referred to the Practice Expense Subcommittee for review.

The meeting was adjourned at 7:35 pm on Saturday, February 1, 2003.

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

September 12-14, 2002

Chicago, Illinois

Bill Moran, MD (Chair)
Kevin Accola, MD*

James Anthony, MD
Deborah Bash, MD
Katherine Bradley, PhD, RN
Ann Cea, MD
Manuel D. Cerqueira, MD
Neal Cohen, MD
Roger Dmochowski, MD*
Thomas A. Felger, MD
Blair Filler, MD
Mary Foto, OTR
Rebecca Johnson, MD*
Ronald Kaufman, MD
James Kelly, MD

Gregory Kwasny, MD
Peter McCreight, MD*

Scott Manaker, MD
James Metcalf, MD
Tye Ouzounian, MD
Julia Pillsbury, DO
Peter Sawchuck, MD*
Anthony Senagore, MD
Ronald Shellow, MD
Daniel Mark Siegel, MD, MS
Susan Spires, MD
David Hitzman, DO*
Craig Strafford, MD
Charles Weissman, MD

*Alternate PEAC Member

I. PEAC 000 and 10 Pre-Time Workgroup

Doctor Cohen presented the report of the PEAC workgroup that developed a recommendation for a standard pre-service time for 000 and 10 day codes. The Workgroup first determined that setting a standard was desirable because the alternative is to have each individual code come forward without any standard to use for relativity. Use of a standard would also create consistency across specialty-specific code families. While the workgroup recommended standard pre-service time, the workgroup also recommended that each code that has been identified as possibly having pre-service time would still need to be presented to the PEAC to justify any time. The workgroup developed the standard with the understanding that they would apply to a limited number of codes, namely those that specialty societies had already identified and also those codes where the PEAC had previously made a recommendation on pre-service time.

The PEAC discussed the differences between the 000 and 10 day standard and the standard for the 90 day codes. While the 90 day code pre-service time was applied across the board, the 000 and 10 day standard will be for a limited number of codes that will need to be presented to the PEAC. This recommendation is significantly different from the previous PEAC recommendation for 90 day codes since the workgroup believed that the recommendation should not apply to all 000 and 10 day codes, with many codes not having any pre-service time. The PEAC approved the workgroup report that will allow the PEAC to refine the pre-service time of 000 and 10 day codes by March, 2003. All remaining 000

and 10 day codes not refined by the PEAC will have a recommendation of zero pre-service time.

The PEAC discussed whether other codes that have not already been identified as possibly having pre-service time would be eligible for pre-service time. The PEAC reviewed the process it established to identify these codes and felt that deadline was established and only those codes already identified would be eligible for the standard time. Specialties are able to request the PEAC for an exception to this rule, but any additional codes eligible for pre-service time would need to be approved by the PEAC.

The PEAC accepted the following recommendations:

- 1. The pre-service standard time allocation of 18 minutes in-office and 30 minutes out of office should be used in conjunction with 000 and 10 day global codes. Specialties will need to justify to the PEAC that individual codes should have the standard applied or that a time less than or greater than the standard should be assigned.**
- 2. The 292- 000 day global codes and the 288- 10 day global codes that have previously been identified by specialty societies as having pre-service time, will be eligible for the application of the standard, if the specialties provide justification for the time.**
- 3. The 000 and 10 day global codes that have previously been reviewed by the PEAC are also eligible for re-review by the PEAC, if a specialty society wishes to submit codes for review again.**
- 4. The PEAC will review the pre-service times for all of the extracted 000 and 10 day codes in a single PEAC meeting, preferably in January, 2003. Any of the codes that have already been assigned pre-service time by the PEAC, but for which specialties would like to resubmit the code, will be reviewed at a subsequent PEAC meeting, preferably in March, 2003.**

In addition, the following PEAC recommendation approved in August, 2001 is amended as follows:

The PEAC recommends that by the ~~September 2002~~ March, 2003 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.

Pre-Service and Post-Service Recommendation for 90 day codes.

The PEAC discussed its previous recommendation approved 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 a methodology for calculating the clinical staff

time associated with the post service office visits. Since any outliers to the pre-service standard will have been reviewed by the PEAC at the conclusion of the September, 2002 PEAC meeting, the PEAC will forward to the RUC the following recommendation:

The PEAC recommends the following pre-service clinical labor time for 090 day global periods except for those codes where the PEAC recommended different times:

Description of Clinical Activities	Out of Office	In Office
Complete pre-service diagnostic & referral form	5	5
Coordinate pre-surgery Services/ Review test/exam results	20	10
Schedule space and equipment in facility	8	0
Office visit before surgery/procedure–Review test/exam results	0	0
Provide pre-service education/obtain consent	20	10
Follow-up phone calls & prescriptions	7	10
Other Activities:	0	0
Total Time	60	35

The PEAC approved the following methodology for the post service time period for 90 day global periods:

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

II. AAOMS Excision and Prosthesis Codes

Two families of codes were presented by the American Academy of Oral and Maxifacial Surgeons (AAOMS) and the American Academy of Maxillofacial Prosthetics. Eight of the 10 excision codes do not have physician time data divided into the standard segments, and without the detailed physician time, the PEAC was unable to refine these codes. The pre-facilitation committee initially refined the inputs for the two codes (21025, 21031) with detailed physician time and recommended that the remaining eight codes be presented to the RUC Practice Expense subcommittee for an allocation of the time. After reviewing the issue in more detail, the specialty society requested to also bring back the two codes that the PEAC with the remainder of the family so that all the codes would be refined at the same time.

The prosthetics code family has similar time issues in that a detailed distribution of physician time was not available. In addition, it became apparent that due to the unique nature of these codes, the standard RUC summary of recommendation form might not be applicable. The presenters explained that the codes involved the preparation of a prosthetic that involved substantial clinical staff time both in the office and in the lab and also involved several patient visits. Given the unique nature of these codes, the PEAC recommended that these codes first go to the RUC for a redistribution of the physician time and then come back to the PEAC. The PEAC also recommended that a more detailed description of the physician time and clinical staff time be presented along with a timeline involving the typical patient. It was suggested that vignettes be developed for these codes to assist in the

review process. The PEAC members stressed that the PEAC is willing to work with the specialty to refine these codes that have never received a full RUC recommendation.

Radiology Codes

The American College of Radiology had prepared to present direct practice expense input recommendations for more than 100 radiological imaging services. These recommendations were based upon a consensus panel process. A pre-facilitation committee of the PEAC met to review these services and became concerned after discussing numerous codes that further review by ACR should be conducted on all of the imaging services. The PEAC also concurred with the pre-facilitation committee, that Radiology should consider whether it is more appropriate to consider a standard or sets of standards regarding the technician time involved in the acquisition of images. For example, is it reasonable to assume that the acquisition of the first image requires X number of minutes and then each additional image should require X number of minutes. The PEAC agreed that ACR should consider this issue and noted that the current set of recommendations include a wide variety of clinical staff times relevant to this activity. The ACR representatives agreed that the specialty should consider this issue and agreed to re-present this issue to the PEAC at a future meeting.

III. Stoma codes

At the March 2002 PEAC meeting the PEAC made the recommendation that 5 additional minutes of pre-service clinical labor time should be applied to procedures where an initial stoma is created. The PEAC also made the recommendation that the specialty societies identify any specific CPT codes where a stoma is created and additional pre-service time is necessary. Specialties then were to submit a list of stoma codes for presentation and approval by the PEAC at the September 2002 meeting. AMA staff received the following 29 codes from the American Academy of Otolaryngology – Head and Neck Surgery, requesting an additional 5 minutes. All of the codes were passed by the PEAC and 5 additional pre-service minutes are recommended.

CPT	Descriptor	Global
15732	Muscle, myocutaneous, or fasciocutaneous flap	90
15756	Free muscle flap with or without skin with microvascular anastomosis	90
15757	Free skin flap with microvascular anastomosis	90
31360	Laryngectomy; total, without radical neck dissection	90
31365	Laryngectomy; total, with radical neck dissection	90
31367	Laryngectomy; subtotal supraglottic, without radical neck dissection	90
31368	Laryngectomy; subtotal supraglottic, with radical neck dissection	90
31370	Partial laryngectomy (hemilaryngectomy); horizontal	90
31375	Partial laryngectomy (hemilaryngectomy); lateroververtical	90
31380	Partial laryngectomy (hemilaryngectomy); anterovertical	90
31382	Partial laryngectomy (hemilaryngectomy); antero-latero-vertical	90
31390	Pharyngolaryngectomy, with radical neck dissection; without reconstruction	90
31395	Pharyngolaryngectomy, with radical neck dissection; with reconstruction	90
31600	Tracheostomy, planned (separate procedure);	0
31601	Tracheostomy, planned (separate procedure); under two years	0
31610	Tracheostomy, fenestration procedure with skin flaps	90

31613	Tracheostoma revision; simple, without flap rotation	90
31614	Tracheostoma revision; complex, with flap rotation	90
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	90
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	90
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	90
41153	Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection	90
41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	90
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	90
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)	90
42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap	90
42892	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls	90
42894	Resection of pharyngeal wall requiring closure with myocutaneous flap	90
61576	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion; requiring splitting of tongue and/or mandible (including tracheostomy)	90

IV. Cleaning of Endoscopes

During the PEAC's discussions of CPT codes relating to Bronchi and Gastrointestinal Endoscopy, the PEAC discussed the possibility of establishing a standard clinical labor time for the cleaning of the endoscopes. It was pointed out that the time it takes to clean an endoscope varies by the type of scope (i.e. Bronchoscope, Nasal Scope, or Sigmoidoscope), and whether it is a rigid or flexible. Where the scope is used is also a variable that should be considered. The PEAC decided that an Endoscope Workgroup might be needed to develop standards for rigid and flexible scopes that could be used across specialties.

V. Future Code Selection

The PEAC discussed its future meeting schedule and the planning for future meetings. Given the significant progress that the PEAC is making, it will be possible to refine a large number of additional codes within the next year. This will result in the PEAC refining codes that represent a large percentage of Medicare charges by the time the PEAC completes its work. The proposal before the PEAC would not result in the refinement of all codes, but would cover a significant majority of the codes. Several proposals were put forward for discussion as methods for future code selection. The PEAC discussed the advantages and disadvantages of each method and agreed on the following code selection criteria. CMS requested that the PEAC review those codes that had their inputs crosswalked by CMS as well as those codes that are in the zero work pool. Also, the PEAC agreed to refine the inputs for the in-office service period for those 90 day global codes with inputs in this setting. Since all of the pre and post-service inputs for 90 day codes are completed, the service period for the in-office setting would be the only inputs remaining.

In addition, there are several other sets of codes that will be placed on future PEAC agendas:

- Conscious sedation codes 99141 and 99142 (March 2003 PEAC meeting)
- ZZZ codes that have been identified by specialty societies as having direct inputs. This will occur after the RUC determines a process for reviewing these codes.
- Three transurethral destruction of prostate codes—53850, 53852, and 53853 (request from CMS) March 2003 PEAC meeting.
- Remaining unrefined E/M codes. (CMS request) March 2003 PEAC meeting.
- Mastectomy code family (January or March 2003 PEAC meeting.)

Once the remaining codes are determined, AMA staff will distribute information on the remaining codes that would not be refined by the time the PEAC completes its project in March 2004. It is anticipated that most high volume codes will have been refined by the end of the PEAC's term.

To accomplish these tasks the PEAC made the following recommendation to the RUC.

The PEAC will continue to refine codes until March 2004.

**AMA/Specialty Society RVS Update Committee
Practice Expense Advisory Committee
000 and 10 day Pre-Service Time Workgroup Recommendation**

Present

PEAC Workgroup

Neal Cohen, MD (chair)

Manuel Cerqueria, MD

Tye Ouzounian, MD

Emil Paganini, MD

Katherine Bradley, RN.

AMA Staff

Patrick Gallagher

Todd Kemp

Absent

James Anthony, MD

Ronald Kaufman, MD

James Kelly, MD

Anthony Senagore, MD.

Introduction

The workgroup began its discussion by reviewing a recommendation that was developed by several specialties (see attached report) that have a number of the 000 and 10 day codes identified as having pre-service clinical staff time. Doctor Ouzounian presented this multi-specialty recommendation. This specialty society workgroup discussed the feasibility of developing standard pre-service times. That workgroup felt that using a standard would expedite the PEAC review process and allow specialty societies to bring large groups of codes forward for review. Standardization would also create consistency across specialty-specific code families and minimize the likelihood of inconsistencies within the code families.

The specialty workgroup considered various methods for grouping the 000 and 10 day codes such as grouping according to global period, grouping based on the need for anesthesia, or based on the urgency of the procedure (urgent vs. elective codes). The specialties concluded that a single standard time could be developed for both 000 and 10 day codes. However, differentiating codes solely on the global period would not be appropriate. The times developed by the specialties were based on an examination of codes already approved by the PEAC, and in particular the out of office times allocated to the cardiac catheterization code family (93508-93533). The specialties recommended 35 minutes of pre-service time be allowed for out of office services and that the time was consistent with the range of times already approved by the PEAC. The in-office time of 20 minutes was proposed.

While this standard was presented to the PEAC workgroup for discussion, Doctor Ouzounian stressed that specialties would still be required to present to the PEAC. The standard would not be automatically be applied to codes, since any pre-service time would need PEAC approval. Specialties will be required to request approval of these standard times or recommend an increase or decrease of pre-service times based on data presented to the PEAC for a code or family of codes.

PEAC Workgroup Development of Standard

The PEAC workgroup carefully examined the specialty proposal and reviewed the methodology. The workgroup concluded that due to inconsistencies in assignment of global periods to codes, differentiation of pre-service times based on global period was not appropriate. The workgroup members felt that it is important to examine the individual code rather than the global period, since some 000 day codes require more pre-service time than 10 day codes. One approach favored by the workgroup was to examine codes and determine if the code is considered an invasive code, with the assumption that such codes would require more clinical staff time. Some workgroup members felt that this was an appropriate distinction, but given the variability in pre-service times for these codes, the workgroup agreed with the recommendation of the specialty societies that any pre-service standard should not be applied automatically, but should undergo a PEAC review.

The workgroup reviewed the specialty society recommendation in detail and reviewed the time assigned to each clinical staff activity. After lengthy discussion, the workgroup modified the times for some of the activities based on an examination of the times already approved by the PEAC for many of these activities and the standard times developed for the 90 day codes. (See below for statistics on the PEAC approved codes) The group noted that the average times for the PEAC-approved codes are lower than the times developed by the specialty society workgroup in large part because a number of the services are performed in conjunction with an E/M visit and the pre-service times were reduced to eliminate duplication.

Codes Reviewed By PEAC

Global Period	Number Reviewed by PEAC	Number With Time	Percentage With Time	Range of Time	Average
000 in office	300	104	35%	2-30	13
000 out office	300	168	56%	5-55	21
10 in office	136	42	31%	5-20	13
10 out office	136	61	45%	4-60	20

After reviewing each clinical staff activity as well as the range of times already approved by the PEAC and the times developed for the 90 day global period codes, the workgroup recommended that standard times of 18 minutes in office and 30 minutes out of office would be an appropriate standard.

The workgroup allocated the times as follows:

	IN-OFFICE	OUT-OFFICE
Complete pre-service diagnostic and referral forms	5	5
Coordinate pre-service surgery services	3	10
Schedule space and equipment in facility	0	5
Provide pre-service education/obtain consent	7	7
Follow-up phone call and prescriptions	3	3
Other Clinical Activity	0	0
TOTAL	18	30

The zero and 10 day codes that specialties have identified as having pre-service time would be eligible to have this standard time applied.

Application of Standard

There was some concern that a standard would become a floor with most specialties not asking for time below the standard, only for time above the standard. While this has occurred with the 90 day standard, a large number of 000 and 10 day codes would still have zero times assigned. For example, the casting codes were reviewed by the PEAC and approved with zero time based on the specialty society recommendation. Only **292** out of 857 of the 000 day global codes and **288** out of 455 of the 10 day codes have been identified by specialty societies as having pre-service time. Therefore, a large number of codes will still have no pre-service time.

Some workgroup members felt that the time could be used as a standard, but that there should be an opportunity to assign lower times if the PEAC felt that a particular code warranted lower time. The PEAC workgroup agreed that the 18 and 30 minutes is an appropriate standard, but codes should not receive this time automatically. Due to the heterogeneity among the 000 and 10 day codes, each code will need to undergo PEAC review to determine if the standard is applicable. Specialties and the PEAC will then need to determine if the standard time is appropriate or whether a lower or higher time is more appropriate given the particular code. The standard should simplify PEAC review but it will not eliminate the need for a critical examination of each code.

The workgroup next discussed which codes would have an opportunity to have the standard applied. There was agreement that initially only those codes identified as having pre-service time and listed in the March, 2002 PEAC agenda book should be eligible to have the standard applied. It was felt that specialty societies pre-service time proposals for these codes should all be reviewed during one meeting. The possibility of reviewing all the inputs for these codes was discussed but the workgroup felt that this would be overwhelming and would not be accomplished in one meeting. To ensure consistency in pre-service times, the workgroup agreed that the PEAC should review the pre-service times for these codes at the same time.

The workgroup then discussed the codes that have already been reviewed by the PEAC and felt that these codes should be given an opportunity to have the standard applied. It was

suggested that specialties should be given a chance to bring codes back to the PEAC. These codes would be eligible for the standard times, but it will be up to the specialty society to bring these codes forward and justify the times.

Conclusion

The workgroup makes the following four recommendations to the PEAC:

- 5. The pre-service standard time allocation of 18 minutes in-office and 30 minutes out of office should be used in conjunction with 000 and 10 day global codes. Specialties will need to justify to the PEAC that individual codes should have the standard applied or that a time less than or greater than the standard should be assigned.**
- 6. The 292- 000 day global codes and the 288- 10 day global codes that have previously been identified by specialty societies as having pre-service time, will be eligible for the application of the standard, if the specialties provide justification for the time.**
- 7. The 000 and 10 day global codes that have previously been reviewed by the PEAC are also eligible for re-review by the PEAC, if a specialty society wishes to submit codes for review again.**
- 8. The PEAC will review the pre-service times for all of the extracted 000 and 10 day codes in a single PEAC meeting, preferably in January, 2003. Any of the codes that have already been assigned pre-service time by the PEAC, but for which specialties would like to resubmit the code, will be reviewed at a subsequent PEAC meeting, preferably in March, 2003.**

In addition, the following PEAC recommendation approved in August, 2001 is amended as follows:

The PEAC recommends that by the ~~September 2002~~ March, 2003 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.

CPT Codes Refined by the PEAC in September 2002

<i>CPT Code</i>	<i>Global</i>	<i>Descriptor</i>	<i>Extent of Refinement *</i>	<i>Specialty(s) Involved</i>
10060	010	DRAINAGE OF SKIN		APMA, AAFP
11000	000	DEBRIDE INFECTED SKIN		APMA
11001	ZZZ	DEBRIDE INFECTED SKIN		APMA
11055	000	TRIM SKIN LESION		APMA
11056	000	TRIM SKIN LESIONS, 2 TO 4		APMA
11057	000	TRIM SKIN LESIONS, OVER 4		APMA

11450	090	REMOVAL, SWEAT GLAND		ACS
11451	090	REMOVAL, SWEAT GLAND		ACS
11462	090	REMOVAL, SWEAT GLAND		ACS
11463	090	REMOVAL, SWEAT GLAND		ACS
11470	090	REMOVAL, SWEAT GLAND		ACS
11471	090	REMOVAL, SWEAT GLAND		ACS
11730	000	REMOVAL OF NAIL PLATE		APMA
11732	ZZZ	REMOVE NAIL PLATE,		APMA
11750	010	REMOVAL OF NAIL BED		APMA
11752	010	REMOVE NAIL BED/FINGER		APMA
11771	090	REMOVAL OF PILONIDAL		ACS
11772	090	REMOVAL OF PILONIDAL		ACS
15732	090	MUSCLE-SKIN GRAFT,	5 min preservice time for initial stoma	AAO-HNS
15756	090	FREE MUSCLE FLAP,	5 min preservice time for initial stoma	AAO-HNS
15757	090	FREE SKIN FLAP,	5 min preservice time for initial stoma	AAO-HNS
16000	000	INITIAL TREATMENT OF		ACS
16010	000	TREATMENT OF BURN(S)		ACS
16015	000	TREATMENT OF BURN(S)		ACS
16020	000	TREATMENT OF BURN(S)		ACS
16025	000	TREATMENT OF BURN(S)		ACS
16030	000	TREATMENT OF BURN(S)		ACS
31231	000	NASAL ENDOSCOPY, DX		AAO-HNS
31233	000	NASAL/SINUS ENDOSCOPY,		AAO-HNS
31235	000	NASAL/SINUS ENDOSCOPY,		AAO-HNS
31360	090	REMOVAL OF LARYNX	5 min preservice time for initial stoma	AAO-HNS
31365	090	REMOVAL OF LARYNX	5 min preservice time for initial stoma	AAO-HNS
31367	090	PARTIAL REMOVAL OF	5 min preservice time for initial stoma	AAO-HNS
31368	090	PARTIAL REMOVAL OF	5 min preservice time for initial stoma	AAO-HNS
31370	090	PARTIAL REMOVAL OF	5 min preservice time for initial stoma	AAO-HNS
31375	090	PARTIAL REMOVAL OF	5 min preservice time for initial stoma	AAO-HNS
31380	090	PARTIAL REMOVAL OF	5 min preservice time for initial stoma	AAO-HNS
31382	090	PARTIAL REMOVAL OF	5 min preservice time for initial stoma	AAO-HNS
31390	090	REMOVAL OF LARYNX &	5 min preservice time for initial stoma	AAO-HNS
31395	090	RECONSTRUCT LARYNX &	5 min preservice time for initial stoma	AAO-HNS
31500	000	INSERT EMERGENCY	Out of office Only	AAO-HNS
31582	090	REVISION OF LARYNX	5 min preservice time for initial stoma	AAO-HNS
31584	090	TREAT LARYNX FRACTURE	5 min preservice time for initial stoma	AAO-HNS
31600	000	INCISION OF WINDPIPE	5 min preservice time for initial stoma	AAO-HNS
31601	000	INCISION OF WINDPIPE	5 min preservice time for initial stoma	AAO-HNS
31610	090	INCISION OF WINDPIPE	5 min preservice time for initial stoma	AAO-HNS
31613	090	REPAIR WINDPIPE	5 min preservice time for initial stoma	AAO-HNS
31614	090	REPAIR WINDPIPE	5 min preservice time for initial stoma	AAO-HNS
31622	000	DX BRONCHOSCOPE/WASH		ACCP
31623	000	DX		ACCP
31624	000	DX		ACCP
31625	000	BRONCHOSCOPY WITH		ACCP
32005	000	TREAT LUNG LINING		ACCP
36000	XXX	PLACE NEEDLE IN VEIN		PEAC
36550	XXX	DECLLOT VASCULAR DEVICE		ASCO, ACR
36600	XXX	WITHDRAWAL OF ARTERIAL		ACCP
36620	000	INSERTION CATHETER,		PEAC
36800	000	INSERTION OF CANNULA		PEAC
41140	090	REMOVAL OF TONGUE	5 min preservice time for initial stoma	AAO-HNS
41145	090	TONGUE REMOVAL, NECK	5 min preservice time for initial stoma	AAO-HNS
41150	090	TONGUE, MOUTH, JAW	5 min preservice time for initial stoma	AAO-HNS
41153	090	TONGUE, MOUTH, NECK	5 min preservice time for initial stoma	AAO-HNS
41155	090	TONGUE, JAW, & NECK	5 min preservice time for initial stoma	AAO-HNS
42842	090	EXTENSIVE SURGERY OF	5 min preservice time for initial stoma	AAO-HNS
* Where the Extent of Refinement is blank, all PE inputs were refined.				
42844	090	EXTENSIVE SURGERY OF	5 min preservice time for initial stoma	AAO-HNS
42845	090	EXTENSIVE SURGERY OF	5 min preservice time for initial stoma	AAO-HNS
42892	090	REVISION OF PHARYNGEAL	5 min preservice time for initial stoma	AAO-HNS
42894	090	REVISION OF PHARYNGEAL	5 min preservice time for initial stoma	AAO-HNS
43235	000	UPPER GI ENDOSCOPY,		ACG, AGA, ASGE
43239	000	UPPER GI ENDOSCOPY,		ACG, AGA, ASGE
43240	000	ESOPH ENDOSCOPE		ACG, AGA, ASGE
43241	000	UPPER GI ENDOSCOPY		ACG, AGA, ASGE
43242	000	UPPER GI ENDOSCOPY W/US		ACG, AGA, ASGE
43243	000	UPPER GI ENDOSCOPY &		ACG, AGA, ASGE

43244 000	UPPER GI		ACG, AGA, ASGE
43245 000	OPERATIVE UPPER GI		ACG, AGA, ASGE
43246 000	PLACE GASTROSTOMY TUBE		ACG, AGA, ASGE
43247 000	OPERATIVE UPPER GI		ACG, AGA, ASGE
43248 000	UPPR GI		ACG, AGA, ASGE
43249 000	ESOPH ENDOSCOPY,		ACG, AGA, ASGE
43250 000	UPPER GI		ACG, AGA, ASGE
43251 000	OPERATIVE UPPER GI		ACG, AGA, ASGE
43255 000	OPERATIVE UPPER GI		ACG, AGA, ASGE
43256 000	UPPR GI ENDOSCOPY W		ACG, AGA, ASGE
43258 000	OPERATIVE UPPER GI		ACG, AGA, ASGE
43259 000	ENDOSCOPIC ULTRASOUND		ACG, AGA, ASGE
43450 000	DILATE ESOPHAGUS		ACG, AGA, ASGE
43453 000	DILATE ESOPHAGUS		ACG, AGA, ASGE
43456 000	DILATE ESOPHAGUS		ACG, AGA, ASGE
43458 000	DILATE ESOPHAGUS		ACG, AGA, ASGE
45331 000	SIGMOIDOSCOPY AND		ACG, AGA, ASGE, ACRoS,
AAFP			
45332 000	SIGMOIDOSCOPY W/FB		ACG, AGA, ASGE, ACRoS,
AAFP			
45333 000	SIGMOIDOSCOPY &		ACG, AGA, ASGE, ACRoS,
AAFP			
45334 000	SIGMOIDOSCOPY FOR		ACG, AGA, ASGE, ACRoS,
AAFP			
45337 000	SIGMOIDOSCOPY &		ACG, AGA, ASGE, ACRoS,
AAFP			
45338 000	SIGMOIDOSCPY W/TUMR		ACG, AGA, ASGE, ACRoS,
AAFP			
45339 000	SIGMOIDOSCOPY W/ABLATE		ACG, AGA, ASGE, ACRoS,
AAFP			
45341 000	SIGMOIDOSCOPY		ACG, AGA, ASGE, ACRoS,
AAFP			
45342 000	SIGMOIDOSCOPY W/US		ACG, AGA, ASGE, ACRoS,
AAFP			
45345 000	SIGMODOSCOPY W/STENT		ACG, AGA, ASGE, ACRoS,
AAFP			
45378 000	DIAGNOSTIC		ACG, AGA, ASGE, ACRoS
45379 000	COLONOSCOPY W/FB		ACG, AGA, ASGE, ACRoS
45380 000	COLONOSCOPY AND		ACG, AGA, ASGE, ACRoS
45382 000	COLONOSCOPY/CONTROL		ACG, AGA, ASGE, ACRoS
45383 000	LESION REMOVAL		ACG, AGA, ASGE, ACRoS
45384 000	LESION REMOVE		ACG, AGA, ASGE, ACRoS
45385 000	LESION REMOVAL		ACG, AGA, ASGE, ACRoS
58670 090	LAPAROSCOPY, TUBAL		ACOG
59812 090	TREATMENT OF		ACOG
59820 090	CARE OF MISCARRIAGE		ACOG
59821 090	TREATMENT OF		ACOG
59830 090	TREAT UTERUS INFECTION		ACOG
59840 010	ABORTION		ACOG
59841 010	ABORTION		ACOG
59850 090	ABORTION		ACOG
59855 090	ABORTION		ACOG
59856 090	ABORTION		ACOG
61576 090	SKULL BASE/BRAINSTEM	5 min preservice time for initial stoma	AAO-HNS
61580 090	CRANIOFACIAL APPROACH,		AAO-HNS
61581 090	CRANIOFACIAL APPROACH,		AAO-HNS
61582 090	CRANIOFACIAL APPROACH,		AAO-HNS
61583 090	CRANIOFACIAL APPROACH,		AAO-HNS
61584 090	ORBITOCRANIAL		AAO-HNS
61585 090	ORBITOCRANIAL		AAO-HNS
61586 090	RESECT NASOPHARYNX,		AAO-HNS
61590 090	INFRATEMPORAL		AAO-HNS
61591 090	INFRATEMPORAL		AAO-HNS
61592 090	ORBITOCRANIAL		AAO-HNS
61595 090	TRANSTEMPORAL		AAO-HNS
61596 090	TRANSCOCHLEAR		AAO-HNS
61597 090	TRANSCONDYLAR		AAO-HNS
61598 090	TRANSPETROSAL		AAO-HNS
61600 090	RESECT/EXCISE CRANIAL		AAO-HNS

* Where the Extent of Refinement is blank, all PE inputs were refined.

61601	090	RESECT/EXCISE CRANIAL	AAO-HNS
61605	090	RESECT/EXCISE CRANIAL	AAO-HNS
61606	090	RESECT/EXCISE CRANIAL	AAO-HNS
61607	090	RESECT/EXCISE CRANIAL	AAO-HNS
61608	090	RESECT/EXCISE CRANIAL	AAO-HNS
61613	090	REMOVE ANEURYSM, SINUS	AAO-HNS
61615	090	RESECT/EXCISE LESION,	AAO-HNS
61616	090	RESECT/EXCISE LESION,	AAO-HNS
64550	000	APPLY NEUROSTIMULATOR	APTA
67208	090	TREATMENT OF RETINAL	AAO, ASCRS
67210	090	TREATMENT OF RETINAL	AAO, ASCRS
67220	090	TREATMENT OF CHOROID	AAO, ASCRS
67227	090	TREATMENT OF RETINAL	AAO, ASCRS
67228	090	TREATMENT OF RETINAL	AAO, ASCRS
76000	XXX	FLUOROSCOPE	AAPMR, ASA, NASS, ACR
76005	XXX	FLUOROGUIDE FOR SPINE	AAPMR, ASA, NASS, ACR
76511	XXX	ECHO EXAM OF EYE	AAO, AOA, ASCRS
76512	XXX	ECHO EXAM OF EYE	AAO, AOA, ASCRS
76513	XXX	ECHO EXAM OF EYE,	AAO, AOA, ASCRS
76516	XXX	ECHO EXAM OF EYE	AAO, AOA, ASCRS
76519	XXX	ECHO EXAM OF EYE	AAO, AOA, ASCRS
76529	XXX	ECHO EXAM OF EYE	AAO, AOA, ASCRS
77280	XXX	SET RADIATION THERAPY	ASTRO, ACRO, ACR
77285	XXX	SET RADIATION THERAPY	ASTRO, ACRO, ACR
77290	XXX	SET RADIATION THERAPY	ASTRO, ACRO, ACR
77300	XXX	RADIATION THERAPY DOSE	ASTRO, ACRO, ACR
77305	XXX	RADIATION THERAPY DOSE	ASTRO, ACRO, ACR
77310	XXX	RADIATION THERAPY DOSE	ASTRO, ACRO, ACR
77315	XXX	RADIATION THERAPY DOSE	ASTRO, ACRO, ACR
77321	XXX	RADIATION THERAPY PORT	ASTRO, ACRO, ACR
77331	XXX	SPECIAL RADIATION	ASTRO, ACRO, ACR
77332	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77333	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77334	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77336	XXX	RADIATION PHYSICS	ASTRO, ACRO, ACR
77370	XXX	RADIATION PHYSICS	ASTRO, ACRO, ACR
77401	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77402	XXX	RADIATION TREATMENT	ASTRO, ACRO
77403	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77404	XXX	RADIATION TREATMENT	ASTRO, ACRO
77406	XXX	RADIATION TREATMENT	ASTRO, ACRO
77407	XXX	RADIATION TREATMENT	ASTRO, ACRO
77408	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77409	XXX	RADIATION TREATMENT	ASTRO, ACRO
77411	XXX	RADIATION TREATMENT	ASTRO, ACRO
77412	XXX	RADIATION TREATMENT	ASTRO, ACRO
77413	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77414	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77416	XXX	RADIATION TREATMENT	ASTRO, ACRO, ACR
77417	XXX	RADIOLOGY PORT FILM(S)	ASTRO, ACRO, ACR
86580	XXX	TB INTRADERMAL TEST	AAFP
90901	000	BIOFEEDBACK TRAIN, ANY	APTA
90911	000	BIOFEEDBACK	APTA
92020	XXX	SPECIAL EYE EVALUATION	AAO, AOA, ASCRS
92100	XXX	SERIAL TONOMETRY	AAO, AOA, ASCRS
92120	XXX	TONOGRAPHY & EYE	AAO, AOA, ASCRS
92130	XXX	WATER PROVOCATION	AAO, AOA, ASCRS
92135	XXX	OPHTHALMIC DX IMAGING	AAO, AOA, ASCRS
92140	XXX	GLAUCOMA PROVOCATIVE	AAO, AOA, ASCRS
92286	XXX	INTERNAL EYE	AAO, AOA, ASCRS
92506	XXX	SPEECH/HEARING	ASHA, AAO-HNS
92507	XXX	SPEECH/HEARING	ASHA, AAO-HNS
92508	XXX	SPEECH/HEARING	ASHA, AAO-HNS
92511	000	NASOPHARYNGOSCOPY	AAO-HNS
92526	XXX	ORAL FUNCTION THERAPY	ASHA, AAO-HNS
92561	XXX	BEKESY AUDIOMETRY,	ASHA, AAO-HNS
92562	XXX	LOUDNESS BALANCE TEST	ASHA, AAO-HNS

* Where the Extent of Refinement is blank, all PE inputs were refined.

92563 XXX TONE DECAY HEARING	ASHA, AAO-HNS
92564 XXX SISI HEARING TEST	ASHA, AAO-HNS
94240 XXX RESIDUAL LUNG CAPACITY	ACCP
94260 XXX THORACIC GAS VOLUME	ACCP
94360 XXX MEASURE AIRFLOW	ACCP
94375 XXX RESPIRATORY FLOW	ACCP
94640 XXX AIRWAY INHALATION	AAFP
94656 XXX INITIAL VENTILATOR MGMT	ACCP
94657 XXX CONTINUED VENTILATOR	ACCP
94664 XXX AEROSOL OR VAPOR	AAFP
94720 XXX MONOXIDE DIFFUSING	ACCP
94760 XXX MEASURE BLOOD OXYGEN	ACCP
94761 XXX MEASURE BLOOD OXYGEN	ACCP
95004 XXX ALLERGY SKIN TESTS	ACCP
AAO-HNS	ACP-ASIM, AAOA, JCAAI,
95010 XXX SENSITIVITY SKIN TESTS	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95015 XXX SENSITIVITY SKIN TESTS	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95024 XXX ALLERGY SKIN TESTS	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95027 XXX SKIN END POINT TITRATION	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95028 XXX ALLERGY SKIN TESTS	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95044 XXX ALLERGY PATCH TESTS	AAD, JCAAI, AAOA, ACP-ASIM
95115 000 IMMUNOTHERAPY, ONE	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95117 000 IMMUNOTHERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95144 000 ANTIGEN THERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95145 000 ANTIGEN THERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95146 000 ANTIGEN THERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95147 000 ANTIGEN THERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95148 000 ANTIGEN THERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95149 000 ANTIGEN THERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95165 000 ANTIGEN THERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95170 000 ANTIGEN THERAPY	ACP-ASIM, AAOA, JCAAI,
AAO-HNS	
95831 XXX LIMB MUSCLE TESTING,	APTA
95832 XXX HAND MUSCLE TESTING,	APTA
95833 XXX BODY MUSCLE TESTING,	APTA
95834 XXX BODY MUSCLE TESTING,	APTA
95851 XXX RANGE OF MOTION	APTA
95852 XXX RANGE OF MOTION	APTA
97150 XXX GROUP THERAPEUTIC	APTA
98925 000 OSTEOPATHIC	AAFP, AOA
98926 000 OSTEOPATHIC	AAFP, AOA
98927 000 OSTEOPATHIC	AAFP, AOA
98928 000 OSTEOPATHIC	AAFP, AOA
98929 000 OSTEOPATHIC	AAFP, AOA

* Where the Extent of Refinement is blank, all PE inputs were refined.

RUC HCPAC Review Board Report

Royal Pacific Resort Universal Studios
Orlando, Florida
January 30, 2003

On January 30, 2003, the RUC HCPAC Board met to approve the revised RUC HCPAC Structure and Functions, to review practice expenses of the codes reviewed and approved by the PEAC and to assess the recommendations for Rehabilitation Assessment and Integration Services codes. The following HCPAC Review Board members participated in the discussion:

Richard Whitten, MD, Chair
Don E. Williamson, OD, Co-Chair
David Keepnews, PhD, JD, RN, FAAN
Mary Foto, OTR
James Georgoulakis, PhD
Robert Fifer, PhD
Bernard Pfeifer, MD

Nelda Spryres, LCSW
Emily H. Hill, PA-C
Joe Johnson, DC
Karen Smith, MS, RD, FADA
Pam Smith, PhD, RD
Nelda Spryres, LCSW

I. Call to Order

Dr. Williamson called the meeting to order at 7:05 a.m.

II. Introduction

Dr. Williamson introduced new RUC HCPAC Review Board members:

- Robert Fifer, PhD, American Speech Hearing and Language Association
- Bernard Pfeifer, MD, RUC representative from the American Academy of Orthopaedic Surgeons

III. Final Approval of the Revised RUC HCPAC Structure and Functions

The Review Board discussed and approved the revised RUC HCPAC Structure and Functions document. This document will be sent to the Administrative Subcommittee for final approval.

IV. Approval of HCPAC Codes submitted to the September PEAC Meeting

The Review Board assessed the recommendations of the HCPAC codes approved at the September PEAC meeting. The Review Board approved these recommendations.

V. Relative Value Recommendations for CPT 2004 Rehabilitation Assessment and Integration Services (97537 and 977XX)

The Review Board recommended that this issue be deferred until the April RUC HCPAC Review Board Meeting.

VI. Other Issues

Dr. Williamson announced that nominations for the RUC HCPAC Co-Chair will be assessed at the April RUC HCPAC Review Board Meeting. The new Co-Chair will assume his/her position at the September RUC HCPAC Meeting.

IV. Adjournment

Dr. Williamson adjourned the meeting at 8:50 a.m.

The RUC Health Care Professionals Advisory Committee Review Board
Organizational Structure and Processes

I. History

The current CPT coding system contains many codes that are used by both MD/DOs and non-MD/DO health care professionals. In some instances, legislation and regulation require the use of CPT codes by non-MD/DO health care professionals. In other instances, third-party payors have retained limiting policies governing how non-MD/DO health care professionals report their services using CPT. In 1992, the American Medical Association Board of Trustees concluded that a Health Care Professionals Advisory Committee (HCPAC) Review Board should be established for both the CPT Editorial Panel and the RVS Update Committee (RUC) to open these processes to all groups legally required to use CPT codes to report their services.

Responding to this recommendation, organizations representing physicians assistants, nurses, occupational and physical therapists, optometrists, podiatrists, psychologists, social workers, audiologists, speech pathologists and later chiropractors and registered dieticians were invited to nominate representatives to the CPT and RUC HCPAC Review Boards. The CPT HCPAC Review Board was created to foster participation by professional organizations representing non-MD/DO providers in coding changes affecting their members. The RUC HCPAC Review Board was developed to allow for participation by these same organizations in the development of relative values for new and revised codes within their scope of practice.

The RUC HCPAC Review Board's composition and functions, described below, will facilitate discussion and decision making on issues of concern to non-MD/DO health care professionals.

II. Composition

A standing RUC HCPAC Review Board was established to facilitate the development of relative value recommendations for codes used by non-MD/DO health care professionals. The non-MD/DO health care professions have been selected from the following criteria:

- The non-MD/DO health care profession must represent professionals who are required to use CPT to report the services they provide independently to Medicare patients under a defined Medicare benefit.
- The non-MD/DO health care profession must represent professionals who are paid for their services based on the RBRVS payment schedule.

When a change in status results for a non-MD/DO health care profession (i.e. a new Medicare benefit), the AMA with consultation from the RUC HCPAC Review Board, will select an appropriate organization to represent that profession based on the non-MD/DO health care professional organization's membership, nation-wide presence and that it is most representative of that non-MD/DO health care profession. In addition, the non-MD/DO health care profession must not already be meaningfully represented by an existing umbrella organization.

Currently, the RUC HCPAC Review Board is comprised of three RUC members and eleven representatives from the following organizations:

- American Nurses Association
- American Physical Therapy Association
- American Speech-Language Hearing Association
- National Association of Social Workers
- American Occupational Therapy Association
- American Psychological Association
- American Optometric Association
- American Chiropractic Association
- American Podiatric Medical Association
- American Dietetic Association
- American Academy of Physician Assistants

III. Terms:

Members of the RUC HCPAC Review Board shall hold terms of three (3) years. The HCPAC organization will appoint representatives.

Chair:

One member of the RUC will serve as the Chair of the RUC HCPAC Review Board. The Chair will be appointed by the RUC Chair. Additionally, the RUC Chair will select the RUC members of the HCPAC. The Chair of the RUC HCPAC Review Board will vote only in the event of a tie.

Co-Chair:

The Co-Chair will be elected by the members of the RUC HCPAC Review Board. The Co-Chair will be eligible for a maximum of two, two-year terms. An alternate Co-Chair will also be elected to serve a maximum of two, two-year terms. The Co-Chair will be slated as one of the eleven non-MD/DO members and will hold a voting seat on the RUC. The Co-Chair will be a voting member of the Review Board.

VI. Functions

The RUC HCPAC Review Board functions shall include but not be limited to:

- Commenting on proposed RVS changes;
- Considering work relative value and direct practice expense input recommendations to the Centers for Medicare and Medicaid Services (CMS);
- Serving on RUC Subcommittees, work groups and facilitation committees
- Identifying and serving as a liaison with the relevant national non-MD/DO health care professional organizations representing non-MD/DO health care professionals.

VII. Processes

The RUC HCPAC Review Board serves as the decision making body to consider work relative value recommendations and direct practice expense inputs. The following Guidelines shall be used:

- The determination of which services are directed to the RUC and which are directed to the RUC HCPAC Review Board will be made based in the Level of Interest Process.
 - If a non-MD/DO health care professional organization solely expresses interest in a code or family of codes, these work relative value recommendations and direct practice expense input recommendations will be made before the RUC HCPAC Review Board.
 - If both MD/DOs and non-MD/DOs health care professionals express interest in developing primary relative value recommendations for a code or a family of codes, MD/DO and non-MD/DO health care professionals will be encouraged to closely coordinate their efforts to develop and present consensus recommendations to the RUC.
- The approved RUC HCPAC Review Board recommendations will be submitted directly to CMS. Like the RUC, a two-thirds majority of the Review Board will be required to adopt recommendations before they can be submitted to CMS.
- All meetings shall be conducted according to Sturgis, Standard Code of Parliamentary Procedure.
- The AMA and the RUC's Research Subcommittee will oversee the methodologies used by the RUC HCPAC Review Board to ensure consistency.
- Also like the RUC, the AMA staff will handle preparation of agenda materials and materials submitted to CMS.

Relative value recommendations submitted by the RUC and those that will be submitted by the RUC HCPAC Review Board, are subject to review by CMS. Following this review, recommendations that are accepted are published by CMS as "interim values" for one year. A 60-day period for public notice and comment follows publication. After CMS responds to the comments, relative values are then published as "final values" for the subsequent year.

**AMA/Specialty Society RVS Update Committee
Zero Work Pool Workgroup
January 30, 2003**

The following workgroup members participated in the Workgroup meeting: Melvin Britton, MD (Chair), Bibb Allen, MD, James Blankenship, MD, MD, Robert Fifer, PhD, William Gee, MD, Stephen Imbeau, MD, David Regan, MD, Susan Strate, MD, J. Baldwin Smith, MD, Richard Tuck, MD, Robert Zwolak, MD.

Doctor Britton began the meeting by stressing the importance of understanding the creation of the methodology that created the zero physician work pool since the methodology has a significant impact on a large number of codes. The current workgroup was convened to examine the many issues related to the zero work pool methodology.

The majority of the meeting dealt with a presentation by Mark Hartstein from CMS. Mr. Hartstein provided a history of the zero work pool and explained that the current methodology is an exception to the existing PE methodology and CMS is interested in having a uniform methodology. Mr. Hartstein explained the overall top down methodology, the creation of the zero physician workpool and the differences in the standard methodology that is applied to the zero work pool. Also discussed were options for changing the zero work pool methodology. For a detailed explanation of the methodologies please refer to tab 22 in the RUC agenda book.

Doctor Zwolak raised several issues pertaining to the methodology. He explained that when the original PE methodology was first published in 1998 there were a number of codes that had significant reductions in PE RVUs. The reductions were so large that the payments would not have covered costs and would have forced providers to no longer offer these services. Therefore, the zero work pool was created as a temporary measure to halt such drastic cuts. Doctor Zwolak explained that the current PE/hr costs for each specialty are based on wide variety of practice settings, and for some specialties, technical services with higher practice expenses may be under reimbursed due to blended specialty PE/hr figures. For example, some cardiology practices may perform primarily E/M services while others provide technical echocardiography services resulting in a very different PE/hr numbers. However, under the current methodology the numbers are blended into a final PE/hr. Use of the blended PE rate for calculation of the technical component PERVU may under value the technical services because the providers of the technical services have a higher cost per hour. It was suggested that a stratified sample may be needed to capture more accurately these costs as well as surveys of technical providers that may not have historically been included in the SMS survey. CMS stressed that they have encouraged specialties to work with the CMS contractor, The Lewin Group, if they were interested in collecting additional practice expense information to ensure the correct type of data are collected. Doctor Zwolak also stated that the scaling of CPEP data has a large impact on PE RVUs the scaling process should be examined. The workgroup members agreed that additional PE data needs to be collected to identify in more detail the practice expenses for certain practice types.

Doctor Allen stated that CMS created the zero physician work pool as a method to value services with no physician work since CMS determined that these services could not be valued using the proposed top down methodology without providing a surrogate for physician work in the formula. Also, the issue of calculating the technical component PERVU by backing it out of the global PERVU needs to be examined closely because there are a variety of practice arrangements that may affect the calculation of these values. For example, a physician may receive a salary from a large provider of technical radiology services, but the provider submits global bills under the physician's

provider number. Although all of these charges are listed as provided by the physician, the site of service is at the employer who incurs the expenses of the high priced equipment. However, for these physicians, their practice expenses reflected in the SMS survey data would not include the high cost of equipment and technical clinical staff expenses.

The workgroup members were asked to identify any additional data needs from CMS prior to the next workgroup meeting. At the next meeting in April the workgroup will examine any additional data that describes the composition of the zero work pool such as top codes and also what role, if any, the RUC will have with this issue. Several workgroup members questioned what additional role the RUC could have in dealing with this issue since it may be more of a specialty specific practice cost issue.

**AMA/Specialty Society RVS Update Committee
Practice Expense Subcommittee Report – January 30, 2003**

The Practice Expense Subcommittee met during the January-February 2003 RUC meeting to continue its work on the reallocation of physician time components, discharge day management allocation, and to discuss existing errors in the RUC database. The following subcommittee members participated: Doctors Levy (Chair), Blankenship, Brill, Gage, Gerety, Lichtenfeld, McCaffree, Moran, Rich, Stanley, and David Hitzeman, DO and Joe Johnson, DC.

Reallocation of Physician Time Components – Status of 227 CPT Codes

At the February 2002 RUC meeting, AMA staff identified 227 non-RUC surveyed 010 and 090 day global CPT codes which have only total time within CMS's database. The PEAC has assigned post operative practice expense inputs according to existing codes through RUC and CMS physician time components. These 227 CPT codes apparently were cross-walked by CMS in some unknown manner. CMS staff have not been able to explain the methodology for which these codes had been cross-walked. In addition, since these codes did not have any time components used for practice expense purposes, only total time, the RUC asked AMA staff to send the list of the 227 codes to specialty societies to ask them to address the following question in regard to these codes:

Do you agree that the physician time is valid?

If the answer to this question is yes, the RUC asked 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 the question 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 the physician time and would have no bearing on physician work.

The subcommittee reviewed 28 codes that were submitted by 3 specialties, however, CPT code 62281 was withdrawn by the North American Spine Society at the RUC meeting.

The American College of Radiology and the Society for Interventional Radiology presented physician time allocation for code 47511. The physician time allocation presented, was crosswalked from non RUC survey codes within the same family, and the total components did not add up to the total time cross-walked by CMS. Subcommittee members were uncomfortable with approving the specialty society's physician time allocation for the code, as it did not conform to the RUC's specific directions of identifying the physician time components.

The specialty societies presenting time for code 47511, have identified a code that they believe has excessive total physician time and were attempting to cross-walk the time from other codes within its code family. Subcommittee members understood that the specialty was trying to prevent rank order anomalies by reducing the CMS physician time, but had no methodology in place to allow for such an allocation based on the time of comparable codes in its family. In an effort to decrease the administrative burden on the specialties, the practice expense subcommittee made the following recommendations:

For this exercise, the RUC should accept a methodology for reducing CMS total physician time for those codes for which a specialty society who predominately

performs the service, believes it is appropriate, by accepting a cross-walk to a similar family of codes that have RUC surveyed times, and/or may use an expert panel.

With this recommendation the subcommittee referred code 47511 back to specialty societies for a new recommendation since it did not meet the methodology described above.

The subcommittee then reviewed 26 recommendations from the American Association of Oral & Maxillofacial Surgeons/American Dental Association. The committee expressed concern regarding the intra service work per unit of time, as the time seemed inaccurate for some of the codes. However, overall the recommendation seemed reasonable and the committee agreed that these codes were appropriately surveyed.

The subcommittee accepted the survey results submitted by the specialties for these 26 codes (21026-21070 and 40800-40831) and recommends them to the RUC for approval. The physician time recommendations for these 26 codes follow this report.

Subcommittee members asked that in the future when specialties submit groups of codes, that they be prepared in a spreadsheet format for the ease of time component review.

The subcommittee members also expressed their concern once again that the physician time recommendations from this exercise are to be administrative for practice expense purposes only and should have no bearing on physician work. Subcommittee members recommended that these codes' data are: **clearly identified within the database as not being allowed to be considered when making work recommendations. This would apply not only for the physician time components from the surveys, but other information contained on the summary of the recommendation forms (ie, the vignette and descriptors of work), would state "DO NOT USE TO VALIDATE FOR PHYSICIAN WORK".**

Since the inception of this exercise, the Subcommittee and the RUC have reviewed and approved 46 CPT code physician time allocations leaving 184 codes to be completed by the April 2003 RUC meeting. The subcommittee asked AMA staff to send another reminder to specialties societies requesting these time allocations. If changes are not submitted to the RUC by **March 17, 2003**, the PEAC be unable to recommend practice expense inputs related to the post-operative visits for these codes.

RUC Database – Possible Errors in Physician Time

Over the past year, AMA staff has proofed all the data elements of the RUC database. Through this review, AMA staff found that there are a number of codes in the database with surveyed physician time in which a work relative value was not approved by the RUC. These codes were entered into the database when physician time was not deemed an important determinate of physician work. Additionally, most of these codes were part of the first 5-year review. From the time of the second 5-year review to the present, surveyed physician time in the RUC database is entered only for codes that were accepted by the RUC, as physician time components are used as a reference while valuing new and revised codes.

AMA staff identified 85 codes in the RUC database where the RUC rationale states that the work value is recommended to be maintained. Since CMS is now using these physician times for their practice expense methodology in creating the practice expense pools for the specialties, and the RUC has used them for recommending work recommendations, the Practice Expense Subcommittee discussed how to handle these records in the RUC database.

AMA staff pointed out that physician time became a more important determinate of the RUC's recommendations in February 2000 when the Practice Expense Subcommittee and the RUC made the recommendation that *"the RUC's acceptance of a specialty society's work RVU explicitly means acceptance of the physician time data collected in the specialty society's survey. If however, the RUC does not approve a work recommendation, a facilitation committee may wish to recommend the original time or an alternative time data"*. Time was never clearly examined prior to this time, and therefore these codes are no less reliable than all the other codes approved by the RUC during this time period. In addition, the subcommittee believed that if the RUC went back to Harvard times, the time may not be more accurate than what is currently in the database. The subcommittee then agreed to recommend that:

The RUC data for these 85 codes identified by AMA staff should be grandfathered and retained in the RUC database. These codes will be identified in the RUC database as "Surveyed Physician Time has Not been Validated by the RUC".

Subcommittee members believed that if there are errors in the database, specialties have the opportunity to correct the errors at the next 5 year review

Discharge Day Management Allocation – Status of Site of Service Assignment

Throughout the PEAC process, the PEAC has struggled with how to apply discharge day management clinical labor time to surgical procedures. The PEAC had assigned discharge day management time according to RUC approved survey data, however, if the code is without RUC approved survey data, the PEAC had assigned the inputs according to CMS data. As the PEAC applied this methodology they realized there wasn't always consistency amongst families of codes, and therefore sought assistance from the RUC. The RUC proposed to look at where the code is predominately performed according to Medicare utilization data for the site of service, and made the following recommendation at its September 2002 meeting:

Administratively, for practice expense purposes, the RUC should allocate a full discharge day management code to those inpatient services and a half a discharge day management time to outpatient or ASC codes as determined by Medicare utilization data, with the caveat that specialty societies may look at their codes to determine place of service and tell the RUC, particularly those for which Medicare volume is lacking where they fit. This does not change the total physician time in the database, as this is an administrative change that will be noted in the database.

For each code, the RUC identified where the service is predominately being performed, whether it be in the office or the facility, and if in the facility whether it be inpatient or outpatient. For a code predominately performed in the office, the assumption is that there would be no associated discharge day planning, even if the procedure is performed in the facility setting.

During the most recent PEAC meeting, the PEAC addressed an alternative proposal from AAOS, ACS, ASGS, and ASCRoS. The proposal suggested the PEAC and RUC should look not only at where the procedure is predominately performed, either in the facility or in the office, but also when the surgical procedure is performed in the facility, whether is it done as an inpatient procedure or an outpatient procedure. Specifically, the proposal from specialty societies was to:

- 1) Allocate 6 minutes of clinical staff time for discharge management for out-of-office locations; unless there is CMS/RUC data (or specialty society input) to indicate that it is most commonly performed as an inpatient procedure. If there is data to support that a procedure is most commonly performed as inpatient, allocate 12 minutes of clinical staff time for discharge management.

On January 27, 2003, the PEAC agreed with the specialty society proposal and recommended the proposal to the Practice Expense Subcommittee and the RUC.

Practice Expense Subcommittee members at this meeting had concerns about allocating clinical labor time according to the proposed methodology, as there are procedures for which the Medicare utilization would not clearly indicate that the service is predominately performed in the facility setting as either an inpatient or outpatient hospital procedure. AMA staff explained that in these situations, the specialty societies would be asked to assist in clarifying what type of hospital visit would be typical. The Subcommittee members were also concerned over the impact of the allocation of clinical labor time for high utilization codes, and suggested that it may be wise to split the difference in time for those high utilization codes where the site of service within the hospital setting is evenly split between inpatient or outpatient. This may also apply for specialties not represented in the Medicare utilization database. AMA staff explained that the proposed standard would reduce the disparities from the prior recommendation of selecting a site of service of either in the office or the hospital setting. In addition, as the PEAC uses the standard, when the typical site of service is not evident from Medicare utilization data, specialties must make a case whether it was appropriate to allocate any clinical staff time for discharge day management in the facility setting.

The Subcommittee agreed with the PEAC's proposed discharge day management practice expense standard to:

Allocate 6 minutes of clinical staff time for discharge management for out-of- office locations; unless there is CMS/RUC data (or specialty society input) to indicate that it is most commonly performed as an inpatient procedure. If there is data to support that a procedure is most commonly performed as inpatient, allocate 12 minutes of clinical staff time for discharge management.

Mechanism for Adding a Non-Facility Practice Expense Component

Physicians have asked specialty societies to create a mechanism for an alteration or addition of a non-facility practice expense component for those codes that they originally surveyed for in facility procedures. An example would be a technology that enables something to move from an ambulatory service center to an office based setting. If the CMS database lists only a facility practice expense, there is no mechanism to accrue a non-facility practice expense. Currently, CMS determines whether there is non-facility or facility practice expenses. CMS generally believes that specialties should decide whether they want practice expenses for the facility or non-facility setting.

As the PEAC will retire in 2004, the subcommittee members agreed that there should be a mechanism to establish a non-facility practice expense as practice patterns change.

The subcommittee asked AMA staff to research these issues and report back to the subcommittee at its next meeting.

CPT Codes with Unaccepted RUC Survey Data – PE Subcommittee – January 31, 2003

11101 BIOPSY, SKIN ADD-ON	31365 REMOVAL OF LARYNX
11750 REMOVAL OF NAIL BED	31580 REVISION OF LARYNX
11752 REMOVE NAIL BED/FINGER TIP	31601 INCISION OF WINDPIPE

19325 ENLARGE BREAST WITH IMPLANT	31603 INCISION OF WINDPIPE
20225 BONE BIOPSY, TROCAR/NEEDLE OPENING	31614 REPAIR WINDPIPE
21125 AUGMENTATION, LOWER JAW BONE WINDPIPE	31780 RECONSTRUCT
21243 RECONSTRUCTION OF JAW JOINT	32000 DRAINAGE OF CHEST
22210 REVISION OF NECK SPINE VALVE	33425 REPAIR OF MITRAL
23420 REPAIR OF SHOULDER CATHETER, VEIN	36489 INSERTION OF
23466 REPAIR SHOULDER CAPSULE ARTERY	36620 INSERTION CATHETER,
23615 TREAT HUMERUS FRACTURE COLLECTION	38230 BONE MARROW
23920 AMPUTATION AT SHOULDER JOINT NODES,	38720 REMOVAL OF LYMPH
24363 REPLACE ELBOW JOINT NODES,	38724 REMOVAL OF LYMPH
24435 REPAIR HUMERUS WITH GRAFT CHEST	39400 VISUALIZATION OF
25107 REMOVE WRIST JOINT CARTILAGE PALATE/LESION	42120 REMOVE
25575 TREAT FRACTURE RADIUS/ULNA	42145 REPAIR PALATE,
25628 TREAT WRIST BONE FRACTURE	42820 REMOVE TONSILS AND
25810 FUSION/GRAFT OF WRIST JOINT URETHRA	52510 DILATION PROSTATIC
26123 RELEASE PALM CONTRACTURE STRICTURE	53600 DILATE URETHRA
26356 REPAIR FINGER/HAND TENDON	57110 REMOVE VAGINA WALL,
26449 RELEASE FOREARM/HAND TENDON AT	64718 REVISE ULNAR NERVE
27049 REMOVE TUMOR, HIP/PELVIS SURGERY	64721 CARPAL TUNNEL
27052 BIOPSY OF HIP JOINT PRESSURE	65820 RELIEVE INNER EYE
27137 REVISE HIP JOINT REPLACEMENT INTRAOCULAR	66825 REPOSITION
27138 REVISE HIP JOINT REPLACEMENT	67966 REVISION OF EYELID
27181 TREAT SLIPPED EPIPHYSIS	90845 PSYCHOANALYSIS
27286 FUSION OF HIP JOINT W/PATIENT	90847 FAMILY PSYTX
27435 INCISION OF KNEE JOINT	90857 INTAC GROUP PSYTX
27488 REMOVAL OF KNEE PROSTHESIS THERAPY	90870 ELECTROCONVULSIVE
27513 TREATMENT OF THIGH FRACTURE THERAPY	90871 ELECTROCONVULSIVE
27536 TREAT KNEE FRACTURE	90880 HYPNOTHERAPY
28002 TREATMENT OF FOOT INFECTION HEART	93320 DOPPLER ECHO EXAM,
28080 REMOVAL OF FOOT LESION	93503 INSERT/PLACE HEART
28114 REMOVAL OF METATARSAL HEADS	93641 ELECTROPHYSIOLOGY

28130 REMOVAL OF ANKLE BONE
PACEMAKER

28292 CORRECTION OF BUNION
WHEEZING

28293 CORRECTION OF BUNION
CHEMO ADMIN

28715 FUSION OF FOOT BONES
CHEMO ADMIN

28730 FUSION OF FOOT BONES
CARE

28735 FUSION OF FOOT BONES
CARE

28737 REVISION OF FOOT BONES
SUBSEQ

30903 CONTROL OF NOSEBLEED

31090 EXPLORATION OF SINUSES

31360 REMOVAL OF LARYNX

93733 TELEPHONE ANALY,

94060 EVALUATION OF

96405 INTRALESIONAL

96406 INTRALESIONAL

99301 NURSING FACILITY

99303 NURSING FACILITY

99313 NURSING FAC CARE,

**Administrative Subcommittee Report
Royal Pacific Resort Orlando, Florida
January 30, 2003**

Doctor Gee called the meeting to order at 12:30 PM. The following members were present: Doctors Hannenberg, Koopmann, Przybylski, Strate, Tuck, Wallner, Whitten, and Nelda Spyras, LCSW. The committee discussed the Structure and Functions document, RUC and PEAC rotating seat elections, joint RUC member and staff lunches, possible locations for the January/February 2004 RUC Meeting, and a recognition dinner for Doctor Hoehn.

I. RUC Structure and Functions

At the September 2002 RUC meeting, the RUC recommended that staff work with general counsel to revise the RUC Structure and Function document. The Administrative Subcommittee reviewed the language revised by staff and the AMA Counsel for criteria for a permanent seat on the RUC. Several members expressed concern that the criterion “The specialty is not meaningfully represented by an umbrella organization” does not state who will make such a determination. Doctor Lichtenfeld recommended adding language to state that meaningful representation will be determined by the RUC. **The Administrative Subcommittee recommends and the RUC approved revising criterion number five of the Structure and Function document to state “The specialty is not meaningfully represented by an umbrella organization, as determined by the RUC.”**

II. Rotating Seat Elections

As RUC members will elect specialty society representatives for opening rotating seats in April 2003, the Administrative Subcommittee discussed the eligible specialties and examined processes to facilitate the election. Those specialty societies that have been appointed to a rotating seat in the previous cycle are not be eligible for nomination for the subsequent cycle.

The following internal medicine subspecialties are eligible for the internal medicine rotating seat to be elected in April: Endocrinology, Gastroenterology, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary Medicine, and Allergy/Immunology. Internal Medicine subspecialties not included on the RUC approved list of specialties are allowed to petition the RUC for the eligibility for an elected Internal Medicine rotating seat, but the specialty would have to petition to be added to the list by the meeting prior to the election and be approved eligible by the RUC.

Candidates will be allowed to present a two page biographical sketch or abbreviated CV. Members agreed that the biographical information in the agenda materials for Doctor Rich provided a good guideline for how candidates could format their information. In addition to the biographical sketch, candidates will have two minutes, or less (at the discretion of the RUC Chair depending on the number of candidates) to present their qualifications before the entire RUC.

Regarding the voting process, the committee determined that a majority, defined as 50 percent plus one vote, is required to elect each seat. The Administrative Subcommittee recommends the following election procedures:

- In the case of four or more candidates, there could be up to three ballots. The first ballot will list all contending candidates. Voters will rank the candidates by assigning points to their choices as follows:

First choice	= 3 points
Second choice	= 2 points
Third choice	= 1 points

No points will be assigned for unranked candidates. A candidate with a majority vote (i.e. greater than 50 percent of the RUC members indicate the candidate as the first choice) will be awarded the seat. In the case of no majority vote, the three candidates garnering the highest number of points will be placed on a second ballot. Voters will then use the process described above to rank the candidates. The candidate with a majority vote will be awarded the seat. In the case of no majority vote, the two candidates garnering the highest points will be placed on a third ballot. From that ballot, the candidate with the majority vote will be elected to the seat.

- In the case of three candidates, there will be two ballots. The first ballot will use the ranking process described above and the second ballot will identify the two candidates with the most points from the first ballot.
- In the case of two candidates, the candidate with the majority vote will be elected to the seat.
- An election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the unchallenged candidate by voice vote.

III. PEAC Rotating Seats

Doctor Moran shared his concern that few candidates have expressed interest in the PEAC rotating seats. To ensure an open process, a letter will be sent to all eligible societies regarding the open PEAC rotating seats. Currently, the term limit rule prevents existing holders of rotating seats to run in the election subsequent to their term. In the case that there are no new candidates for the rotating seats, the Administrative Subcommittee determined that this rule should be suspended to allow existing seats to renew their two-year term. In the case that there is only one new candidate for any of the two internal medicine seats, the PEAC will elect two candidates from the existing candidates and the new candidate will be awarded the open seat. In the case that there is more than one new candidate, the current term limit rule will apply (i.e. the current representatives of the rotating seat will be ineligible). For the other rotating seat, the incumbent will not be eligible if there are other candidates.

IV. Joint Lunches for RUC Members and Staff

Several specialty society staff and Advisory Committee (AC) members have brought the issue of lunches for staff and AC to the attention of the Administrative Subcommittee Chair. Both specialty society staff and AC members feel that joint lunches are a valuable portion of the RUC process, as they facilitate the goals of the RUC. Currently, lunches are only provided for the RUC members and alternates. Doctor Koopmann and other subcommittee members suggested that a request be made to the AMA to cover the cost of these lunches. The Administrative Subcommittee recommends that the emphasis of this request should frame this issue in the context of the significant contributions that the RUC continues to provide to the AMA and organized medicine through its integral role in the CPT process.

V. Possible Locations for the January/February 2004 RUC Meeting

The site of the January/February 2004 RUC meeting has not yet been selected. The Administrative Subcommittee suggested possible locations, including Arizona (Phoenix, Tucson, Scottsdale), San Diego, and Orlando. The Administrative Subcommittee recommended referring this issue to the RUC for discussion.

VI. Recognition Dinner

In April 2003, Doctor Hoehn will fulfill his term as RUC Chair. To show our gratitude and appreciation of Doctor Hoehn's leadership, there will be a recognition dinner for Doctor Hoehn during RUC meeting in Chicago, Saturday, April 26, 2003. Details regarding this dinner will follow.

**AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
January 30, 2003**

On January 30, 2003, the Research Subcommittee met to discuss a variety of issues including revisions to the RUC survey methodology. The following subcommittee members were in attendance: Doctors James Borgsdede (chair), James Blankenship, Neil Brooks, Melvin Britton, John Derr, Bernard Pfeifer, Peter Smith, Don Williamson, OD, and Robert Zwolak.

I. Multiple Code Survey

The Research Subcommittee discussed with the ACOG presenters, ACOG's experience in using a reformatted RUC survey that was used for a series of Laparoscopy codes. The Research Subcommittee previously reviewed the survey as a template that can be used by other specialties in the future and wanted to learn about ACOG's experiences in using the survey. The intent was to standardize the reformatting that is currently done on an adhoc basis, helping to ensure that specialty societies use a standard format when surveying multiple codes.

The ACOG presenters discussed their experiences in using the reformatted survey and found that it led to a higher response rate and much more accurate data than a prior attempt when six separate surveys were used. ACOG concluded that the reformatted survey was a successful endeavor and requests that the Subcommittee approve the use of the reformatted survey for future surveys of code families. The Research Subcommittee agreed that the reformatted survey could be used as a template and the RUC approved the following recommendation:

The RUC endorses the reformatted RUC survey instrument for use in surveying families of codes.

II. Central Venous Access Workgroup

Marie Mindeman (AMA CPT staff) presented a document that contained the proposed clinical vignettes for a series of central venous access codes. A CPT Workgroup developed these codes and vignettes and recently submitted the vignettes to the CPT panel for approval. Since the RUC members did not have time to review the document prior to the meeting, they agreed to provide CPT staff with any comments prior to the February CPT meeting next week, which is when the CPT panel will review the vignettes. The RUC will review the relative value recommendations for these codes at the April RUC meeting.

Intensity/Complexity Calculation

The RUC recently clarified its survey instructions to explicitly state the RUC's methodology for calculating the physician time and mean intensity/complexity measurements. Currently the RUC instructions state that the median physician time data and the mean intensity/complexity measurements should be based on all survey responses, not just those that chose the reference service that is reported on the summary of recommendation form. An alternative methodology would be to calculate the intensity measurements based only on those responses that used the same reference service. During the discussion it became clear that specialties have been using a variety of methods for calculating the time and intensity measures. Some specialties have been using the data only from the respondents that selected the same reference service to calculate intensity measures.

The Subcommittee discussed the pros and cons of calculating these measures in different ways and concluded that when multiple reference codes were selected by the survey respondents, the values reported for the time and intensity measures should be calculated based on the responses that used the same reference service reported on the summary of recommendation form. Since this number of responses will be lower than the number of respondents currently reported on the summary of recommendation form, the Subcommittee felt that the number of respondents that chose the reference service on the summary form should be listed. Time values should be based on all respondents.

The Subcommittee agreed that the RUC survey instructions be revised and the RUC approved the following:

For the new and revised codes, calculate physician time based on all responses, but calculate intensity data only from those responses that chose the reference code listed on the summary of recommendation form. In addition, the number of respondents that chose the reference service on the summary form should be listed.

III. Alternative Methodologies

Doctor Koopman clarified his request for allowing the use of physician panels to develop physician work RVU recommendations. The current proposal is to allow expert panels to develop work recommendations only when the specialty has determined that a survey was not possible or that the results were determined to be unreliable. The Subcommittee discussed this proposal in great detail and several members were concerned that allowing the use of panels could lead to biased data and also be used in place of the standard RUC survey. The Subcommittee concluded that the RUC survey remains the primary source of determining RVU recommendations, but an expert panel could be used if a specialty society determined that the data received from administering the survey was flawed or a panel could be used to supplement survey results. The Subcommittee also agreed that the specialty society that presented panel data needed to justify to the RUC their rationale for not using data from the RUC survey since the RUC survey methodology is still considered the primary method for developing work relative value recommendations. Specialties would not be required to obtain prior RUC approval for using this alternative methodology, however, specialties that do not use the RUC survey data run the risk of not receiving approval of their recommendation developed by an expert panel if the justification is not accepted by the RUC.

The Subcommittee agreed to insert in the RUC instruction document under the heading “*Alternative ways to develop work relative value recommendations*” a statement allowing the use of expert physician panels as an alternative methodology. The subcommittee felt that it was up to the specialty to justify to the RUC the use of expert panels as with the use of any alternative methodology. The Subcommittee felt it was important for the specialty society to share the flawed data, explain why it is flawed, and clearly explain the composition of the expert panel and demonstrate why it was necessary to convene an expert panel. However, the RUC would not set parameters for the composition of the expert panel and leave that to the discretion of the specialty society. The RUC survey instructions document will indicate that specialty societies should provide information on the composition of the panel.

The Subcommittee recommends that the new language be added to the RUC survey instruction document as another option for an alternative way to develop work relative value recommendations.

The RUC approved that the following recommendation be added to the RUC survey instructions:

The survey remains the primary source of information to value physician work for codes submitted to the RUC. Expert panel methodology may be submitted if a specialty society determines that the survey may be flawed or needs to be supplemented. A specialty society that chooses to use an expert panel as its primary source of developing a work relative value recommendation must present the survey data and their rationale for using the expert panel.

IV. Typical Patient and Blended Patient Populations

The Research Subcommittee also discussed whether a change in RUC methodology is needed to account for different patient populations that are covered under a single code. Doctor Koopman stated that in certain instances, a typical patient may not accurately describe the range of patients undergoing a procedure and the RUC should examine other situations that would involve using blended patient populations. This would involve situations where several specific patient populations comprise the universe of patients that are covered by a specific code.

The Subcommittee agreed that if there are such instances where a single code can not adequately describe a typical scenario, then a specialty society should pursue the development of new CPT codes to account for differences in the physician work. Depending on how the existing code was valued, the issue of budget neutrality would need to be addressed since in some cases budget neutrality may need to be applied. For example, if a new code is developed for a complex procedure with a specific patient population that existed previously and was reported under the old code when it was developed, then it might be appropriate to apply budget neutrality. Based on the discussion the Subcommittee recommends to:

Make no changes in current RUC methodological standard pertaining to the typical patient.

V. Change in Definition of the ZZZ Global Period

During the September, 2002 RUC meeting, the Research Subcommittee discussed the proposed change in the definition of ZZZ codes. The RUC had requested CMS to change the definition for ZZZ codes to delete the word “intra-service” from the definition of ZZZ codes.

With the recent publication of the Final Rule, CMS finalized its decision regarding the ZZZ definition change and has accepted the RUC recommendation. As agreed to at the last RUC meeting, the RUC will ask specialties to identify any ZZZ codes whose physician work may be affected by the definition change. Once the list is compiled and presented to the Subcommittee in April, the Research Subcommittee will discuss the issue further and determine if the RUC should review these codes outside of the five-year review process. The Research Subcommittee is not making a recommendation on this issue at this time but will address it again during the April RUC meeting.

**AMA/Specialty Society RVS Update Committee
Conscious Sedation Workgroup
Thursday, January 30, 2003**

The Conscious Sedation Workgroup met on Friday, January 30 to discuss several issues related to the provision of conscious sedation. The following members were in attendance: Doctors William F. Gee (Chair), James Blankenship, Neil Brooks, John Derr, Lanny Garvar, Alexander Hannenberg, Charles Mick, Alan Plummer, J. Baldwin Smith, Richard Tuck, and David Keepnews, RN.

I. Review of List of CPT Codes Where Conscious Sedation is Inherent

At the April 2002 RUC meeting, the RUC agreed to ask specialty societies to review their services and indicate which CPT codes, in today's practice, inherently include conscious sedation. Twenty-eight medical specialty societies and HCPAC organizations responded to this request. AMA staff compiled the list of more than 250 CPT codes identified by the specialties for review at the September 2002 RUC meeting. At that meeting, the Workgroup agreed that the list of 250+ codes should be re-circulated to all of the specialty societies with additional definition and explanation. For example, the Workgroup agreed that the codes should be included whether IV or oral conscious sedation is inherently provided. In addition, it was clarified that only services where the sedation services are administered by or under the supervision of the operator (physician performing the procedures) should be included. If conscious sedation is an inherent part of the procedure, but is most typically provided by an anesthesiologist or CRNA, the code should not be included in the specialty's list.

Fifty-three specialty societies responded to this second review of the conscious sedation list. These responses were used to create a new list of 226 CPT codes that met the above criteria. However, specialties differed on their recommendations for 27 CPT codes. In general this disagreement was based on the issues surrounding whether the service is more typically provided to an adult or pediatric patient. For one category of these services, the pediatricians have indicated that they typically utilize conscious sedation when performing the procedure, while the society which predominately performs the procedures indicate that they do not typically utilize conscious sedation for adult patients. The workgroup agrees that for this category, the services should not be included on the conscious sedation list. If conscious sedation is utilized then it would be reported separately. The Workgroup, therefore, agreed to remove the following nominated codes from the list:

- 47000 *Biopsy of liver, needle; percutaneous*
- 74360 *Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation*
- 74363 *Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation*
- 75600 *Aortography, thoracic, without serialography, radiological supervision and interpretation*
- 75605 *Aortography, thoracic, by serialography, radiological supervision and interpretation*
- 75625 *Aortography, abdominal, by serialography, radiological supervision and interpretation*
- 75630 *Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation*
- 75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*
- 75960 *Transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel*
- 75984 *Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abscess), radiological supervision and interpretation*

- 75989 *Radiological guidance for percutaneous drainage of abscess,, or specimen collection (ie, fluoroscopy, ultrasound, or computed axial tomography), with placement of indwelling catheter, radiological supervision and interpretation*
- 76003 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)*

In addition, the pediatricians had noted that a number of the codes on the proposed list would typically be performed under general anesthesia, rather than conscious sedation, for the pediatric patient. Therefore, the Workgroup reviewed the list to determine which codes were more commonly performed on pediatric patients. This review resulted in the removal of the following codes:

- 92990 *Percutaneous balloon valvuloplasty; pulmonary valve*
- 92992 *Atrial septectomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)*
- 92993 *Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)*
- 92997 *Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel*
- 92998 *each additional vessel*
- 93531 *Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies*
- 93532 *Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies*
- 93533 *Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies*

II. Clarification of Vignettes and Descriptions of Work

At the April 2002 Conscious Sedation Workgroup meeting, concern was expressed that some specialties did not respond to the request to identify codes and others may not have identified a complete list of codes that inherently include conscious sedation in today's practice. The Workgroup identified twenty CPT codes (eg, 49021 *Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*) in which sedation is discussed in the information in the RUC database (pre, intra, or post-service work descriptions). A letter was sent to three specialty societies requesting them to review the issue again and address/clarify the vignettes and descriptions of work for these services.

Two specialties (ophthalmology and otolaryngology) responded that the seven codes (31233, 31235, 31237, 31571, 67207, 67316, and 67900) that were identified from the RUC database either 1) do not typically require conscious sedation or 2) the conscious sedation by an anesthesiologist. The specialties recommended minor editorial revisions to the vignettes. The Workgroup agreed that these clarifications are appropriate and do not effect the past valuation of these services.

The RUC also sent a letter to interventional radiology requesting the specialty to review thirteen specific CPT codes identified through the review of the RUC database of vignettes. The specialty responded that one of the codes identified, 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)*, should be added to the conscious sedation list. The specialty also indicated that the vignettes for the percutaneous abscess drainage codes (44901, 47011, 48511, 49021, 49041, 49061, 50021, and 58823) were designed to reflect local variation in conscious sedation administration between anesthesiologists and the operating

physician. The Workgroup was concerned that the physicians responding to the survey for these abscess drainage codes may have considered the work of conscious sedation in their valuation as the vignettes in the RUC data base clearly state that conscious sedation was administered in conjunction with the procedure. In addition, the Workgroup would like the interventional radiologists to address the vignettes related to CPT codes 32201, 35472, 49423, and 49424. The Workgroup recommends that another letter be sent to interventional radiology to re-review these codes, along with other codes in the family, to assess whether conscious sedation is inherent to the procedure. The Workgroup will request that this information be presented at their April meeting.

III. PEAC Update

The RUC had requested that the PEAC review the direct practice expense inputs for the stand-alone conscious sedation codes (CPT codes 99141 and 99142). The PEAC has recommended that the CPT codes be revised to differentiate between the initial 15 minutes of the procedure and each additional 15 minutes of monitoring time. It was determined that this would provide the only reasonable way to determine resources required to perform conscious sedation related to many disparate procedures with varying intra-service time. The Workgroup agreed with this approach and will recommend that CPT consider these revisions when the CPT proposal is developed for the entire conscious sedation issue.

The PEAC has established standards for conscious sedation which include the following:

- 2 minutes RN time for initiation of sedation
- 100% of intra-service physician time for RN time
- 15 minutes of RN time for each hour of monitoring following the procedure
- medical supplies and equipment related to the provision of conscious sedation

VII. Conclusions

The Workgroup intends to finalize a coding proposal on this issue at the April 2003 meeting, which will include a list of codes where conscious sedation is inherent to the procedure and the suggested revision to the current conscious sedation stand alone code family. This proposal will be reviewed by the RUC in April. It is anticipated that any recommendations to the CPT Editorial Panel would be considered in the CPT 2005 cycle.

The Workgroup also recommends that an update on this project be included in the RUC comment letter to CMS to initiate a dialogue on the issue. In particular, the Workgroup would be interested in learning whether CMS has any questions or concerns regarding the list that will be discussed and finalized in April. The RUC and CPT effort on this issue is to initiate a policy change where CMS will begin separate payment for conscious sedation for those services that do not inherently include conscious sedation. It is important to understand any CMS suggestions or concerns regarding this effort prior to the conclusion of the Workgroup's recommendations.

Physician Time Components From the February 2003 RUC Meeting

CPT Code	Pre-serv time	Intra-Serv time	Post Time, Same Day of Surgery	99231 @ 19 min	99232 @ 30 min	99233 @ 41 min	99238 @ 36 min	99212 @ 15 min	99213 @ 23 min	99214 @ 38 min	# 99215 @ 59 min	Total Time	Global Period
43752	5	20	5									30	XXX
58545	60	120	30		1		1		2			322	090
58546	60	180	30		1		1		2			382	090
58550	60	100	30	2			1	1	2			325	090
58552	60	120	30	2			1	1	2			345	090
58553	60	150	37.5	1	1		1		2			378.5	090
58554	60	167.5	37.5	1	1		1	1	2			411	090
225X1	120	170	30	3	2		1	1	3			557	090
225X2	116	180	30	3	1		1	1	3			533	090
225X3		60										60	ZZZ
630X1	130	215	43	4	2		1	1	3			644	090
630X2	130	205	40	4	2		1	1	3			631	090
630X3		60										60	ZZZ
657X1	60	60	17				0.5	10				305	090
657X2	60	90	25				0.5	10				343	090
657X3	60	83	25				0.5	9				321	090
657X4	30	20	17				0.5	4				145	010
8542X	10	12.5	12.5									35	XXX
9599X	10	20	7									37	XXX
95990		0										0	XXX