AMA/Specialty RVS Update Committee
Meeting Minutes
February 2-5, 2006

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, February 3, 2006, at 8:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, Jr., MD
James Anthony, MD*
Michael D. Bishop, MD
James Blankenship, MD
Dale Blasier, MD*
Ronald Burd, MD*
Norman A. Cohen, MD
Bruce Deitchman, MD*
James Denneny, MD*
John Derr, Jr., MD
Verdi DiSesa, MD*
Thomas A. Felger, MD
Mary Foto, OTR
John O. Gage, MD
William F. Gee, MD*
Robert S. Gerstle, MD*
David F. Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
George F. Kwass, MD*
Walt Larimore, MD*
M. Douglas Leahy, MD*
Barbara Levy, MD
Brenda Lewis, DO*
J. Leonard Lichtenfeld, MD
Charles D. Mabry, MD*
James D. Maloney, MD*
Scott Manaker, MD
Charles Mick, MD
Bill Moran, Jr., MD
Bernard Pfeifer, MD
Aland Plummer, MD*
Gregory Przybylski, MD
Sandra Reed, MD*
David Regan, MD
James B. Regan, MD
Chester W. Schmidt, Jr., MD
Daniel Mark Siegel, MD
Samuel Silver, MD*
J. Baldwin Smith, III, MD
Peter Smith, MD
Clair Tibiletti, MD*
Trexler Topping, MD
Arthur Traugott, MD*
Richard Tuck, MD
James C. Waldorf, MD*
Richard W. Whitten, MD

*Alternate

II. Chair's Report

Doctor Rich made the following announcements:

- Doctor Rich discussed the following:
  - Financial Disclosure Statements must be submitted to AMA staff prior to presenting. If a form is not signed prior to your presentation, you will not be allowed to present.

- For new codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PERC recommendations or PEAC standards. If the society has not accepted PERC recommendations or PEAC conventions, the tab will be immediately referred to a Facilitation Committee before any work relative value and practice expense discussion.

- Doctor Rich announced that this will be the last meeting for one of the original RUC members, Chester W. Schmidt, Jr., MD, from the American Psychiatric Association, and thanked him for all his years of contributing his expertise and time to the RUC.

- Doctor Rich welcomed Ronald Burd, MD, as a new RUC member from the American Psychiatric Association.

- Doctor Rich welcomed the CMS Staff attending the meeting, which included:
  - Edith Hambrick, MD, CMS Medical Officer
  - Carolyn Mullen, Deputy Director of the Division of Practitioner Services
  - Ken Simon, MD, CMS Medical Officer
  - Pam West, PT, DPT, MPH

- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
  - Kevin Hayes
  - Nancy Ray
  - Ariel Winter

- Doctor Rich welcomed the Practice Expense Review Committee (PERC) Members attending. The members in attendance for this meeting were:
  - James Anthony, MD
  - Katherine Bradley, PhD, RN
  - Joel Brill, MD
  - Neal Cohen, MD
  - Thomas Felger, MD
  - Peter McCreight, MD
  - Bill Moran, MD
  - Tye Ouzounian, MD
  - James Regan, MD

- Doctor Rich welcomed the following Medicare Contractor Medical Director:
    - William J. Mangold, Jr., MD

- Doctor Rich welcomed Keun-Young Lee, MD, PhD, from the Korean Medical Association (Korean Society of Obstetrics and Gynecology).

- Doctor Rich announced the members of the Facilitation Committees:

<u>Facilitation Committee #1</u>
Bernard Pfeifer, MD (Chair)
Michael D. Bishop, MD
Keith Brandt, MD
Norman A. Cohen, MD
Thomas A. Felger, MD
Anthony Hamm, DC
Charles F. Koopmann, Jr., MD
Scott Manaker, MD
James B. Regan, MD
Chester W. Schmidt, Jr., MD
Richard W. Whitten, MD

<u>Facilitation Committee #2</u>
Peter Smith, MD (Chair)
Mary Foto, OTR
John O. Gage, MD
Robert Kossmann, MD
Charles Mick, MD
David Regan, MD
Daniel Mark Siegel, MD
J. Baldwin Smith, MD
Richard H. Tuck, MD
Trexler Topping, MD
Arthur Traugott, MD

<u>Facilitation Committee #3</u>
J. Leonard Lichtenfeld, MD (Chair)
Bibb Allen, Jr., MD
James Blankenship, MD
John Derr, MD
Emily H. Hill, PA-C
David Hitzeman, DO
Barbara Levy, MD
Terry M. Mills, MD
Willard Moran, MD
Gregory Przybylski, MD
Susan Strate, MD

- The following individuals were observers at the September 2005 meeting:
  - Savonne Alford - American College of Obstetricians and Gynecologists
  - David Beyer, MD - American Society for Therapeutic Radiology and Oncology
  - Michael Bigby - American Academy of Dermatology
  - James Christmas, MD - American College of Obstetricians and Gynecologists
  - Scott Collins – American Academy of Dermatology
  - Scott Faro – American Society of Neuroradiology
  - Hal Folander – Society of Interventional Radiology
  - James Giblin, MD – American Urological Association
  - John Hart, MD – American Academy of Neurology
  - Alyssa Herman, MD – American Academy of Dermatology
  - Pat Jacob, MD – American Association of Neurological Surgeons
  - Kirk Kanter - American Association for Thoracic Surgery
  - Michael Kuettel, MD – American Society for Therapeutic Radiology and Oncology
  - Debra Lansey – American Society for Therapeutic Radiology and Oncology
  - Alex Mason, MD – American Association of Neurological Surgeons
  - Christina Metzler – American Occupational Therapy Association
  - Stephen Rao, PhD – American Psychological Association
  - Michael Repka, MD – American Academy of Ophthalmology
  - Koryn Rubin – American Academy of Ophthalmology
  - Chad Rubin, MD – American College of Surgeons
  - James Scroggs – American College of Obstetricians and Gynecologists
  - Craig Sobolewski, MD – American College of Obstetricians and Gynecologists
  - Anthony Spina – American Association of Oral and Maxillofacial Surgeons
  - Ron Szabat – American Society of Anesthesiologists
  - Clare Thompson-Smith – American Nurses Association
  - Vince Traynelis, MD – American Association of Neurological Surgeons
  - Chris Welch – American Association of Clinical Endocrinologists
  - Franklin West – Society for Vascular Surgery
  - Kadyn Williams – American Academy of Audiology

III. Directors Report

Sherry Smith made the following announcements:

- We have had a series of organizational changes at the AMA. Lee Stillwell the Senior Vice President of Advocacy for the AMA has retired in the fall and Richard Deem has been promoted to fill that position.
- Kathy Kuntzman, Vice President of Health Policy at the AMA will be retiring at the end of February. Ms. Smith thanked her for her twenty-three years of service.
- Patrick Gallagher has left the AMA and is now Vice President of Government Affairs for the Illinois State Medical Society (ISMS). Sherry will be the Director of the Department of Physician Payment Policy and Systems.
- Ruby-Overton Bridges is the new staff assistant for the Department of Physician Payment Policy and Systems.
- Farewell and thanks to specialty society staff, Mike Mabry on all his work with the RUC since its inception. He started with the American

College of Radiology, moved to the Society of Interventional Radiology, and will now be the Executive Director of Radiology Business Management Association.

- The next RUC meeting will be in Chicago, April 27-20, 2006, at the Hyatt Regency. The September 2006 meeting location is not finalized but will most likely be held in Washington, DC. The February 2007 meeting will be held in San Diego at the Omni Hotel.
- RUC Database is available with all the 2006 information. An improvement that we would like to add to the database, which will need to be discussed, is to add data from Medicare's five percent sample file. This may include the associated diagnosis, number of diagnoses, patient age, etc. Unfortunately, we will not be able to obtain the date of service data due to privacy issues.
- The 2006 Physician's Guide and CPT 2006 books will be mailed out the week of February 6-10, 2006, to all RUC members and alternates.
- RUC voting is not saved electronically and is usually not stated at the RUC meeting. The votes were in the E/M minutes because this was verbally requested and stated at the last meeting.

IV. Approval of Minutes for the September 29-October 2, 2005, RUC meeting:

The RUC reviewed the minutes and made an editorial change, to the rationale for the Doppler Color Flow Add-On.

(Page 25)
Doppler Color Flow Add-On – 93325

~~Workgroup Four had come to no consensus for code 93325 *Doppler echocardiography color flow velocity mapping* (21005 Work RVU = 0.07) during its discussions, and the RUC then reviewed the code in relation to coes 93307 *Echhocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode regording; complete* (2005 Work RVU = 0.92) and 99320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display* (2005 Work RVU = 0.38). The RUC noted that these three codes are frequently billed together over 92% of the time, and believed that all three codes should be repackaged into one code.~~ **~~The RUC referred code 933525 to the CPT Editorial Panel for review.~~**

The RUC reviewed the specialty's survey results and rationale and believed that code 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete (work RVU = 0.92) was typically billed with 93325. The RUC could not recommend a change in the value of the code without CPT review of the code. **The RUC recommends code 93325 be referred to the CPT Editorial Panel for consideration for inclusion of the work of 93325 in the work of 93307.**

V. CPT Editorial Panel Update

Doctor Peter Hollmann informed the RUC that:

- Most of the issues from the Five-Year Review have made there way to the CPT Editorial Panel, those that have not are indicated in a list prepared by AMA staff in the agenda book as not on the CPT agenda. In some cases there are codes that CMS requested for review.
- CPT and the RUC has formed a group to review all the modifiers in CPT and part of the origin is to review the modifier -51 exempt list that appears in CPT.
- CPT will begin the open meeting format at the June 2006 CPT Editorial Panel meeting. The movement of the meetings to this format was encouraged by the AMA Board of Trustees, and would allow attendance and inclusion of both presenters and registered guests during the entire meeting, with the exclusion of the Executive Session.
- There will be an Editorial Board established for CPT Assistant so that this publication is authoritative.

VI. CMS Update

- Doctor Ken Simon briefed the RUC on CMS' focus on quality. CMS is currently developing a voluntary reporting system, and has been working closely with the CPT Editorial Panel on CPT Category II codes. The Physician Voluntary Reporting Program (PVRP) became operational in 2006.
- Doctor Simon announced that CMS is developing the infrastructure for ASC Prospective Payment System which will become operational in spring 2008.
- Carolyn Mullen announced that CMS is holding an open town hall meeting on practice expense methodology at CMS headquarters on February 15, 2006. The meeting intends to clarify what was in the 2005 *Proposed Rule* (which CMS withdrew in the *Final Rule*) and to discuss improvements in practice expense methodology.
- A RUC member questioned Doctor Simon regarding the decision to carrier price moderate sedation. Ms. Smith indicated that she believes CMS wanted to collect utilization prior to making a decision on what would be the appropriate valuation. Doctor Simon indicated that once the data is collected and analyzed, CMS can then make determinations on whether the services will be continue to be carrier priced or whether they will price them. Doctor Simon indicated that any changes will be listed in the Proposed Rule.
- A RUC member requested that CMS publish RUC recommendations even if CMS does not reimburse these services under the Physician Payment Schedule. Doctor Simon indicated that this has been under discussion for some time and CMS has published some recommendations for services not covered by the Medicare program,

however, this is still under discussion. It was noted that the RUC has made this request to CMS many times in the past.

VII. CMD Update

Doctor William Mangold provided the RUC with an update on the following issues:

- Medicare Administrative Contracting (MAC) process is currently in progress. The first region, region three, will be awarded June 1, 2006 and the subsequent parts of the country will follow over the next two years.
- Durable Medical Equipment (DME) contracts have been awarded already, two months ago. One of the regions has been protested by the previous incumbent.
- In the HCPAC meeting on February 2, 2006, a couple of issues arose (regarding the reporting of the psychological, neurobehavioral and neuropsychological testing codes) that involved incorrect processing determinations by contractors. Doctor Mangold has begun discussions with two contractors and this issue will be clarified soon.

VIII. Washington Update

Sharon McIlrath updated the RUC on the issues included in the Deficit Reduction Act (DRA), which was approved on February 1, 2006. The DRA replaced the 4.4% cut to the Medicare conversion factor that took effect on January 1, 2006, with a payment freeze. It may take until July 2006 for everyone to be properly reimbursed for their claims from January. The AMA is pleased that we were able to halt the cut to the conversion factor, however we continue our campaign to fix the SGR. The multiple procedure reductions savings will not be redistributed among all other practice expenses as CMS has done in the past. The DRA states that starting in 2007, budget neutrality will not apply and instead any savings will go to the government.

A RUC member questioned if the new and revised codes that went through the RUC in 2005, will be valued at CMS' recommended value, since there is no 2005 precedent, if the freeze is signed by the president? Ms. McIlrath responded that this law effects the conversion factor, everything else in the 2006 Final Rule applies. Therefore the new RVUs apply and the conversion factor would be the 2005 conversion factor.

Ms. McIlrath also stated that the bill indicated:

- Ambulatory Surgical Center (ASC) payments will be held to no higher than the Hospital Outpatient Prospective System rate.
- Therapy caps will apply, but there will be some sort of exception process for medically necessary services.
- The Medicaid provisions were extremely controversial, allowing states to increase co-payments.

Ms. McIlrath noted that the pay for performance provisions that were in the Senate package were not included in the final legislation.

MedPAC Update:
Kevin Hayes, from the Medicare Payment Advisory Commission (MedPAC), provided the RUC with an update on the Commission's activities regarding valuing physician services and ways to improve the Five-Year Review. The Commission's report that will address these matters will be submitted to Congress on March 1, 2006, includes four recommendations. There is a focus on identifying potentially overvalued services in the Medicare Physician Payment Schedule. The Commission sees that the process currently appears to do a good job identifying undervalued services, but there is some potential to look further at overvalued services. The report includes recommendations such as CMS' use of an expert panel to help with identifying overvalued services, greater use of data on volume growth, changes in site of service, and a focus on new services. The Commissioners developed an appreciation for the hard work that the RUC and CMS exert. Meetings with the various specialty societies, CMS staff, and a letter from Doctor Rich in September, and meetings with Doctor Rich and Sherry all helped the Commissioners to understand the RUC process better and provide recommendations. The Commissioners have an understanding that much of what they are proposing involves an additional burden on CMS and calls for Congress to give the agency the resources needed and administrative flexibility to address these issues.

MedPAC will also be working on issues regarding primary care and medical student choices about their careers. Additionally, MedPAC will be preparing a report on the sustainable growth rate (SGR) mechanism and alternatives to it. Those alternatives will require MedPAC to review ways to reconfigure the mechanism to look at payment adjustments and updates.

IX. Relative Value Recommendations for the Five-Year Review

Destruction of Lesions (Tab 4)
Bruce Deitchman, MD, American Academy of Dermatology (AAD)
Terri Mills, MD, American Academy of Family Physicians (AAFP)
Facilitation Committee #1

The RUC discussed 17004 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, 15 or more lesions* as it is a rank order anomaly issue created by the Five-Year Review. The RUC addressed several issues regarding this procedure including the difference in work between the 17000

family of codes (17000, 17003 and 17004) and the 17110 family of codes (17110 and 17111). It was determined that all procedures performed on pre-malignant lesions would be addressed in the 17000 family of codes while all procedures performed on benign lesions (other than skin tags or cutaneous vascular lesions) would be addressed in the 17110 family of codes. **The RUC recommends that this issue be referred to the CPT Editorial Panel so that this action will be reflected in the corresponding CPT coding descriptors. Furthermore, the RUC recommends to the CPT Editorial Panel that these changes in the descriptors are editorial in nature. The RUC recommends the editorial changes in the following CPT Code descriptors.**

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), ~~all benign or~~ premalignant lesions (eg, actinic keratoses) ~~other than skin tags or cutaneous vascular proliferative lesions~~; first lesion
17003 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), ~~all benign or~~ premalignant lesions (eg, actinic keratoses) ~~other than skin tags or cutaneous vascular proliferative lesions~~; second through 14 lesions, each (List separately in addition to code for first lesion)
(Use 17003 in conjunction with code 17000)
17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), ~~all benign or~~ premalignant lesions (eg, actinic keratoses) ~~other than skin tags or cutaneous vascular proliferative lesions~~, 15 or more lesions
(For destruction of common or plantar warts, see 17110, 17111)
17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions ~~flat warts, molluscum contagiosum, or milia~~; up to 14 lesions
17111 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions 15 or more lesions
~~(For destruction of common or plantar warts, see 17000, 17003, 17004)~~
The RUC discussed these changes and how they would impact the work associated with 17004. The RUC agreed that these editorial changes would allow for differences within the description of work of these two code families to be greater defined. The RUC charged the specialty society to create changes to the intra-service description of service of 17000-17004 to accurately reflect the additional work of 17000-17004 as compared to 17110-17111.

The RUC recommends the following description of intra-service for 17000-17004:

Inspect and palpate lesions for size, location, functional risks, depth. Administer local anesthetic, if needed. Destruction of lesions to include multiple freeze/thaw cycles with appropriate lateral margins and depth into papillary dermis, or similar margins via other destructive modalities. Control of bleeding as needed.

The RUC recommends the following description of intra-service for 17110-17111:

Inspect and palpate lesion for size, location, functional risks, depth. Administer local anesthetic, if needed. Destruction of lesion by chosen modality. Control of bleeding as needed.

Due to the changes in the intra-service work descriptions, the RUC discussed the intra-service time that should be associated with 17004 and compared this time to the intra-service time of 17111. The RUC felt that due to the recommended changes made to the descriptors, that the 75th percentile of intra-service time for 17004, 20 minutes, was appropriate when compared to the intra-service time of 17111, 10 minutes. **The RUC recommends the 75th percentile of intra-service time, 20 minutes, for 17004.**

Due to the clarification of descriptors, description of intra-service time and adjusted intra-service work, the RUC felt that the specialty society recommended 1.80 work RVUs, half way between the 25th and median survey percentile for 17004, was appropriate. In addition, the RUC noted that the surveyed code 17004 requires greater mental effort and judgment, technical skill, intensity and time in comparison to the reference code 17111 (Work RVU=0.92) and felt that the value of 1.80 work RVUs appropriately values the surveyed code in relation to the reference code. Furthermore, the RUC agreed that 17004 indeed had slightly less work associated with it than 11750 *Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;* (Work RVU=1.86) with 10 minutes pre-service time, 15 minutes of intra-service time, 10 minutes of post service time and 2-99213 office visits. **The RUC recommends 1.80 work RVUs for 17004.**

<u>Cardiothoracic Surgery (Tab 5)</u>
James Levett, MD, Society of Thoracic Surgeons (STS)

The RUC received materials for this tab from STS after the due date. The RUC approved by two-thirds vote to allow consideration of this issue.

The RUC, during the third Five Year Review reviewed various cardiothoracic surgery procedures. In their review of these codes, the RUC determined that several of the reference service codes (33506, 33660, 33670, 33770 and

33780) used in the analysis of surveyed codes had inaccurate physician times associated with them. Some of these codes were reviewed in the second Five Year Review and were assigned time based on crosswalking the pre and post-service inputs to a reference procedure because it was felt that the survey times were inaccurate due to a very low response rate. The remainder of the codes had their times calculated using small sample sizes which presently seem to be potentially inaccurate. Therefore the RUC instructed the specialty society to conduct a survey of time for these reference codes, however, these times could not be used to justify new relative values. The RUC reviewed the specialty society's proposed times for these codes and felt that they accurately reflected the times it takes to perform the procedure as attached to this summary. **The RUC recommends amended physician times for the following cardiothoracic surgery procedures: 33506, 33660, 33670, 33770 and 33780**.

Colectomy (Tab 6)
Charles Mabry, MD, American College of Surgeons (ACS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCRS)
Charles Shoemaker, MD, American Society of General Surgeons (ASGS)

Upon reviewing the partial colectomy codes 44140 *Colectomy, partial; with anastomosis* and 44143 *Colectomy, partial; with end colostomy and closure of distal segment* as part of the Five Year Review, it was determined that several codes also needed to be reviewed in order to avoid rank order anomalies including 44141, 44144, 44145, 44146 and 44147.

44141 *Colectomy, partial; with skin level cecostomy or colostomy*
In contrast to key reference code 44140 *Colectomy, partial; with anastomosis* (Work RVU = 20.97), code 44141 *Colectomy, partial; with skin level cecostomy or colostomy* is emergent in high risk patients. The intra-operative intensity, complexity, and physician work for 44141 is greater than code 44140 because these cases are usually urgent or emergent procedures and the area of the colon involved is usually associated with inflammation or obstruction. The RUC observed that the dissection is made more difficult because the surgeon does not have the advantage of the normal anatomical planes of dissection and isolation of other organs becomes more difficult (i.e. the ureters). Because the bowel is not properly prepped preoperatively, the associated inflammation or chronic dilatation of the colon prohibits construction of an anastomosis. Pre-operative and post-operative work for 44141 is greater than 44140 because of the colostomy. The RUC felt that the survey median RVW of 27.00 is appropriate for 44141 as this value accounts for the additional work (both time and intensity) compared with 44140. **The RUC recommends 27.00 RVUs for 44141.**

44144 *Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula*
In contrast to key reference code 44140 *Colectomy, partial; with anastomosis* (Work RVU = 20.97), code 44144 *Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula* is emergent in high risk patients. The intra-operative intensity, complexity, and physician work for 44144 is greater than code 44140 because these cases are usually urgent or emergent procedures and the area of the colon involved is usually associated with inflammation or obstruction. The RUC observed that the dissection is made more difficult because the surgeon does not have the advantage of the normal anatomical planes of dissection and isolation of other organs becomes more difficult (i.e. the ureters). Because the bowel is not properly prepped preoperatively, the associated inflammation or chronic dilatation of the colon prohibits construction of an anastomosis. The mucus fistula is constructed because of concern for a possible "blow out "of the stump or distal colon. Also, the mucous fistula may be utilized for easier access when the patient is returned to the operating room at a later date for reconstruction of normal gastrointestinal continuity. Pre-operative and postoperative work for 44144 is greater than 44140 because of the colostomy. The RUC felt that the survey median RVW of 27.00 is appropriate for 44144. This value accounts for the additional work (both time and intensity) compared with 44140. **The RUC recommends 27.00 RVUs for 44144.**

44145 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis)*
Code 44145 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis)* describes an operation that occurs within the pelvis and may involve radiated tissues. It also refers to two sets of patients, one with malignancy (more typically) and one with a chronic inflammatory process, such as diverticulitis. Both types of patients involve operative mobilization of the entire left colon. The RUC observed that the intra-operative work and post-operative care is greater for 44145, compared with 44140 *Colectomy, partial; with anastomosis* (Work RVU = 20.97), because there is an addition of the pelvic dissection for mobilization of the rectum. This includes careful dissection for isolation of both ureters, and isolation and salvaging of the hypogastric plexus in order to prevent injury to sexual function and urinary bladder function. Care must be taken not to injure the presacral veins. When an anastomosis is constructed in the pelvis there is an increased incidence of anastomotic leak there by increasing the post-operative morbidity. Although the intra-operative intensity/complexity and time is greater than 44141 and 44144, the post-op work for 44145 is slightly less. Therefore, the RUC recommends maintaining the current RVW of 26.38 for 44145, instead of the survey median RVW. The current RVW of 26.38 accounts for the additional work necessary compared with 44140 and the slightly less total work compared with 44141 and 44145. Along with the recommendation to maintain the current RVW of 26.38 for 44145, the RUC recommends the new

survey time and visit data to correctly reflect current practice. **The RUC recommends to maintain the value of 26.38 work RVUs for 44145.**

44146 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy*
Code 44146 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy* represents a difficult cancer operation deep within the pelvis. The low pelvic anastomosis is often subject to complications and commonly involves pre-operatively radiated tissues. The risks of complication are significant due to the lateral pelvic sidewall dissection, the low anastomosis and the radiation- related confounding factors. The RUC observed that the pre-operative and postoperative work for 44146 is greater than 44207 *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)* (Work RVU=29.96) because of the colostomy. The RUC recommends the survey median RVW of 33.00 for 44146 as this value results in an IWPUT of 0.088 which is correctly less than the laparoscopic reference code 44207 (0.104), but takes into account the additional intra-operative time, greater length of stay, and additional work related to the stoma. **The RUC recommends 33.00 work RVUs for 44146.**

44147 *Colectomy, partial; abdominal and transanal approach*
Code 44147 *Colectomy, partial; abdominal and transanal approach* is a transanal resection of the rectosigmoid colon that requires intussusception of the rectosigmoid and then a resection of the procidentia through a dissection at the level of the anal sphincters. The complex areas involve preserving remaining sphincter function, securing the mesenteric vasculature through the anus, and blindly "yanking" down the sigmoid to reach the anal verge without tearing the colon or injuring the spleen. The RUC observed that the key reference code, 45112 *Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)* (Work RVU=30.49) requires mobilization of the entire rectum from its attachments, including both ureters, bladder, hypogastric plexus, nervi erecti in the prostate bed and the presacral veins; prolapsing the distal rectum and then bringing the proximal colon through the anus; performing a colorectal anastomosis; and placing the anastomosis back through the anus. Although the technical aspect of 44147 and 45112 is different, the total work (pre, intra, and post) is very similar. The RUC recommends the survey median RVW of 31.00 for 44147 as this value appropriately places this procedure among its family. **The RUC recommends 31.00 work RVUs for 44147.**

Practice Expense
The RUC noted that the only practice expense input changes for these codes, being part of the Five Year Review Process, will be changes in physician assist time if the service is priced in the non-facility and the number and level of office visits. For these codes, as they are only priced in the facility, changes were made only to the number and level of office visits. The RUC

has made these changes to the preceding codes and these changes are reflected in the summary forms as attached. However, the RUC wanted to further emphasize that for these codes, the RUC, when initially reviewing the practice expense inputs, recommended to have an additional 7 minutes for the first post-operative office visit for the extra time required to care for stomas, to ensure that this time is not lost during this review of the codes. The practice expense summary form and spreadsheets are attached to this recommendation.

Evaluation and Management (Tab 7)
Douglas Leahy, MD, American College of Physicians (ACP)
Walt Larimore, MD, American Academy of Family Physicians (AAFP)
Edward Diamond, MD, American College of Chest Physicians (ACCP)
James Anthony, MD, American Academy of Neurology (AAN)
Alan Plummer, MD, American College of Chest Physicians (ACCP)
Larry Martinelli, MD, Infectious Diseases Society of America (IDSA)
Joseph Schledt, DO, American Osteopathic Association (AOA)

The following members of the Evaluation and Management (E/M) Workgroup participated in four conference calls (October 19, November 28, December 14, and January 5) to consider interim and postponed actions related to E/M services in the third, Five-Year Review of the RBRVS: Doctors Norman Cohen, Chairman, John Derr, William Gee, David Hitzeman, George Kwass, Doug Leahy, Charles Mabry, Greg Przybylski, J. Baldwin Smith, and Maurits Wiersema.

The Workgroup concluded that all survey data collected by the medical specialties and the surgical specialties should be collated and weighted by Medicare utilization data, similar to the process utilized in the first, Five-Year Review of the RBRVS. The complete analysis of the weighted survey data is included within the attachments to this recommendation. **The RUC concluded that the collated weighted survey data from all survey respondents should be utilized in determining physician time on an interim basis.** This recommended time is included in the spreadsheet attached to these minutes. The RUC agreed that the physician time related to E/M service will continued to be studied when the RUC engages in a long-term review of E/M services.

After considering the extensive discussions of the E/M Workgroup, the RUC completed its review of CPT codes 99213, 99214, 99215, 99222, 99223, 99232, 99233, 99291, and 99292. The final recommendations for each individual E/M code are listed below:

99213
The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service

in that the assumptions made by Harvard and CMS are flawed. The RUC extensively discussed 99213 and agreed that 99213 (pre = 3, intra = 15, and post = 5) is slightly more work than 99202 (recommended work RVU = 0.88, pre = 2, intra = 15, and post = 5). It was noted the content for 99213 represents a higher level of intensity as the medical decision making is "low" for 99213, versus "straightforward" for 99202. CMS also provided utilization data that indicated that diagnosis and number of diagnoses were more significant for 99213 than 99202. Finally, the survey respondents agreed with this relationship, as the survey median work RVU for "all" survey respondents was 1.10 for 99213 and 1.05 for 99202. Utilizing this relationship and the recommended work RVU of 0.88 for 99202, the RUC determined that a work RVU of 0.92 for 99213 is appropriate. In addition, the RUC agreed that 99213 is similar in work to 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete (work relative value = 0.92, pre = 5, intra = 18, and post = 5), which is a code included on the RUC's Multi-Specialty Points of Comparison (MPC). It was also noted that the 25th percentile of the "all" survey respondent, weighted survey data was 0.95. **The RUC recommends a work RVU of 0.92 for 99213, and physician times of pre = 3, intra = 15, and post = 5.**

99214

The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The RUC compared 99214 (time: pre = 5, intra = 25, post = 10, total = 40) to 99309 Subsequent nursing facility care (work RVU = 1.42, time: pre = 10, intra = 20, post = 10, total = 40). Both services require 2 out of 3 of a detailed history, detailed physical, and moderate decision-making. The 25th percentile of the "all" survey respondent weighted data was 1.50 for 99214. The RUC also agreed that 99214 should be valued higher than 99203. **The RUC recommends a work RVU of 1.42 for 99214 and times: pre = 5, intra = 25, and post =10.**

99215

The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The RUC did not agree with the key reference service selected by the survey respondents. Reference service 99350 Home Visit (work RVU = 3.03, pre = 15, intra = 72, post = 20) is not appropriate as the time is much greater than 99215 (pre = 5, intra = 35, and post = 15). A more appropriate reference service is 99349 (work RVU = 2.02, pre = 10 , intra = 40 , and post = 15). The work of 99215 is also similar to 99233 Subsequent hospital visit (recommended work RVU = 2.00, pre = 10, intra = 30, and post = 15). The 25th percentile of the medical society survey data was also 2.00. **The RUC recommends a work RVU of 2.00 for 99215 and time of pre = 5, intra = 35, and post = 15.**

99222
The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The reference service selected was not appropriate as 99235 Observation Care (work RVU = 3.41, time: pre = 10, intra = 75, post = 15) requires 100 minutes of total time, compared to a total survey time of 75 minutes for 99222. A more appropriate reference service is 99234 Observation Care (work RVU = 2.56; time: pre = 10, intra = 60, post = 15). 99222 requires more work than the following services: 90847 Family psychotherapy (work RVU = 2.21; time: pre = 5, intra = 50, post = 21); 99343 Home visit (work RVU = 2.27 ; time: pre = 15, intra = 50 , post = 17); and 99299 Subsequent ICU care for low birth weight newborn (work RVU = 2.50; time: pre = 10, intra = 30, post = 15). 99222 is more intense that 99204 New Office Visit, Level 4 (recommended work RVU = 2.30, time: pre = 5, intra = 30, post = 10). Considering all of these comparisons, it appears that a crosswalk to 99234 is most appropriate. **A work relative value of 2.56 and times of pre = 15, intra = 40, and post = 20 minutes are recommended for 99222.**

99223
The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. More than ninety percent of the survey respondents indicated that the work in performing this service had changed. However, the reference service selected was not appropriate as 99236 Observation Care (work RVU = 4.26) as this code includes an admission and discharge. A more appropriate reference service is 99345 Home Visit (work RVU = 3.78; time: pre = 50, intra = 90, post = 30). A work RVU of 3.78 would be between the 25th percentile and the survey median. **A work relative value of 3.78 and times of pre = 15, intra = 55, and post = 20 minutes are recommended for 99223.**

99232
The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The RUC agreed that as the average length of hospital stay has declined, the subsequent hospital visits have become more intense. The reference service (99235 Observation Care, work RVU = 3.41; time: pre = 10, intra = 75, and post = 15) selected is also not appropriate as this code includes an admission and discharge and requires significantly more time than 99232 (40 minutes total). In the first, Five-Year Review of the RBRVS, the RUC recommended 1.30 for this service. CPT code 99348 Home visit (work RVU = 1.26; time: pre = 9,

intra = 30, post = 10) is a more appropriate reference service. The work of 99232 is similar to 99214 (recommended work RVU = 1.42; time: pre = 5, intra = 25, post = 10), while 99232 reflects greater intensity, 99214 requires more intra-service time. The RUC also agreed that 99232 should be valued higher than 99203. **A work relative value of 1.39 and times of pre = 10, intra = 20, and post = 10 minutes are recommended for 99232.**

99233

The RUC agreed that the compelling evidence to review this E/M service is that incorrect assumptions were made in the previous valuation of the service in that the assumptions made by Harvard and CMS are flawed. The RUC agreed that as the average length of hospital stay has declined, the subsequent hospital visits have become more intense. The reference service (99236 Observation Care, work RVU = 4.26; total time = 110 minutes) selected is also not appropriate as this code includes an admission and discharge and requires significantly more time than 99233 (55 minutes total). A more appropriate reference service is 99349 Home visit (work RVU = 2.02; time: pre = 10, intra = 40, post = 15. The work of 99233 is similar to 99215 (recommended work RVU = 2.00; time: pre = 5, intra = 35, post = 15). The 25th percentile and median of the survey are both 2.00 and this appears to be the appropriate relative value for this service. **A work relative value of 2.00 and times of pre = 10, intra = 30, and post = 15 minutes are recommended for 99233.**

99291

Unlike other E/M services under review, an argument that the current valuation of critical care was based on a flawed assumption was not presented. In fact, these services have been reviewed by the RUC on a number of occasions. It was noted that the specialty has presented survey data beyond the 4.00 on numerous occasions. The rationale that the patient population is more complex does not meet the compelling evidence standards as one could argue that services provided to patients as a whole have become more complex. No evidence was presented that critical care services differ greatly in their increased complexity from other services. However, in order to prevent a rank order anomaly, it is recommended that 99291 be increased to the 25th percentile (work RVU = 4.50) of those 80 respondents who indicated that the vignette was typical. The increase in a work to 4.50 will retain its relationship to 99255 Inpatient Consultation (recommended work RVU = 4.00). The recommended time is pre = 15, intra = 40, and post = 15. It should be noted that there was a great deal of discussion regarding the CPT definition of time and the RUC survey instrument definition of time. The two descriptions appear consistent as any time spent on the floor, including time spent with the patient's family and other activities more typically thought of as pre and post service work, are included in the intra-service time. Time away from the patient's floor could be captured as pre and post time. **A work**

relative value of 4.50 and times of pre = 15, intra = 40, and post = 15 minutes are recommended for 99291.

99292

Unlike other E/M services under review, an argument that the current valuation of critical care was based on a flawed assumption was not presented. In fact, these services have been reviewed by the RUC on a number of occasions. The rationale that the patient population is more complex does not meet the compelling evidence standards as one could argue that services provided to patients as a whole have become more complex. No evidence was presented that critical care services differ greatly in their increased complexity from other services. However, in order to prevent a rank order anomaly, it is recommended that 99291 be increased to the 25th percentile of 4.50 to retain its relationship to 99255 Inpatient Consultation (recommended work RVU = 4.00). 99292 should also then be increased to be reflective of 50% of the work of 99291, or 2.25 work RVUs. Time: 30 minutes of intra-service time is recommended for this add-on code. **A work relative value of 2.25 and times of intra=30 minutes are recommended for 99292.**

Finally, the RUC recommends that the full increase of the E/M be incorporated into the surgical global periods for each CPT code with a global of 010 and 090. The RUC agrees that E/M work is equivalent and a crosswalk of 100% of the E/M valuation should be bundled into the codes with global periods of 010 and 090 days, with appropriate documentation. In addition, the RUC recommends that the maternity codes (global MMM) also be increased to incorporate the E/M increases, as CMS did in the first, Five-Year Review of the RBRVS (page 59534, November 22, 1996 *Federal Register*). A spreadsheet will be submitted to CMS that itemizes the recommended physician time and work relative value for each CPT code to incorporate the E/M increases.

X. Relative Value Recommendations for CPT 2007

Lumbar Arthroplasty (Tab 8)

Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS)
Claire Tibiletti, MD, North American Spine Society (NASS)
John Wilson, MD, American Association of Neurological Surgeons (AANS)

The CPT Editorial Panel created three new codes to report lumbar arthroplasty, a new treatment option for patients requiring surgical treatment of symptomatic degenerative disc disease which has been refractory to conservative measures. Total disk arthroplasty is an important alternative form of open surgical treatment in patients who wish to avoid fusion and have failed non-operative therapy.

228X1

The RUC reviewed the survey data for 228X1 *Total disc arthroplasty (artificial disc), including anterior approach, including diskectomy to prepare interspace (other than for decompression), lumbar, single interspace* in comparison to the reference code 22558 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar* (Work RVU=22.25). The RUC noted that the surveyed code had more physician time associated with it than the reference code, 527 minutes and 502 minutes, respectively. In addition, the surveyed code required greater mental effort and judgment to perform and was deemed more intense than the reference code. However, the specialty society, in its recommendation, felt that the level of office visits associated with the surveyed code was inaccurate and replaced a 99214 office visit with a 99213 office visit. Therefore, when making their final recommendation, the specialty society removed the work associated with 99214 office visit and added the work associated with the 99213 office visit to the 25th percentile, 25.50 work RVUs resulting in a value of 25.07. The RUC felt that this value was appropriately supported by the survey data. **The RUC recommends 25.07 work RVUs for 228X1.**

228X2

The RUC reviewed the survey data for 228X2 *Revision including replacement of total disc arthroplasty (artificial disc) including anterior approach, lumbar, single interspace (includes approach)* in comparison to the reference 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 segment* (Work RVU=35.52). The RUC noted that the surveyed code had more physician time associated with it than the reference code, 679 minutes and 664 minutes, respectively. In addition, the surveyed code required greater mental effort and judgment to perform and was deemed more intense than the reference code. However, the specialty society, in its recommendation, felt that the level of office visits associated with the surveyed code was inaccurate and replaced a 99214 office visit with a 99213 office visit. Therefore, when making their final recommendation, the specialty society removed the work associated with 99214 office visit and added the work associated with the 99213 office visit to the 25th percentile, 31.00 work RVUs resulting in a value of 30.57. The RUC felt that this value was appropriately supported by the survey data. **The RUC recommends 30.57 work RVUs for 228X2.**

228X3

The RUC reviewed the survey data for 228X3 *Removal of total disc arthroplasty (artificial disc), including anterior approach, lumbar, single interspace* in comparison to the reference 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 segment* (Work RVU=35.52). The RUC was informed by the specialty that although the median intra-service time for this procedure was 180 minutes, this value was calculated by physicians who had performed the procedure and those who had not. When the specialty society reviewed the survey data solely from those who had performed the procedure, they observed that the median survey time for this subset was 210 minutes. The specialty society felt that this intra-service time more accurately reflected in the intra-service time for this procedure. The RUC agreed with this recommendation. In addition, the specialty society, in its recommendation, felt that the level of office visits associated with the surveyed code was inaccurate and replaced a 99214 office visit with a 99213 office visit. The RUC noted that the surveyed code, with these changes in the intra-service time and office visit level had less physician time associated with it than the reference code, 617 minutes and 664 minutes, respectively. However, the surveyed code required greater mental effort and judgment to perform and was deemed more intense than the reference code. Therefore, when making their final recommendation, the specialty society removed the work associated with 99214 office visit and added the work associated with the 99213 office visit to the 25th percentile, 30.00 work RVUs resulting in a value of 29.57. The RUC felt that this value was appropriately supported by the survey data and accurately placed this code amongst its family. **The RUC recommends 29.57 work RVUs for 228X3.**

Practice Expense

The RUC carefully reviewed of the inputs for all three procedures and agreed with the specialty society that 75 minutes of pre-service time was deemed appropriate due to the standard set by the spine surgeons at the March 2002 PEAC meeting where the Spine Arthrodesis family of codes 22548 – 22830 were given 75 minutes of pre-service time due to their overall complexity. The RUC also altered the practice expense inputs for all three procedures to reflect the change in the level of office visit from 3-99213 and 1-99214 to 4-99213 office visits. The practice expense inputs were approved as amended.

New Technology

As part of the new process established by the RUC for identifying new technology, this code has been identified as utilizing new technology and will be flagged in the RUC database to return to the RUC for re-review once this technology has become widespread.

Distal Radius Fracture (Tab 9)
Dale Blasier, MD, American Academy of Orthopaedic Surgeons (AAOS)
Daniel Nagle, MD, American Society for Surgery of the Hand (ASSH)

At the 2005 Five-Year Review meeting, the RUC referred code 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* to the CPT Editorial Panel to create a simpler method of classification to report distal radius fractures. At the October 2005 CPT Editorial Panel, the Editorial Panel deleted code 25620, created four new codes and revised two codes, to precisely describe the variations of total work necessary to repair a fracture of the distal radius and ulnar styloid.

The RUC reviewed codes 25600 and 25605 and agreed that the change was editorial and that the work RVUs remain the same. **The RUC recommends to maintain the work RVU of 2.63 for code 25600 and 5.80 for code 25605.**

The RUC reviewed code 2561X1 *Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation* and compared it to codes 24582 *Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation* (work RVU=8.54) and 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* (work RVU=8.54). The RUC felt that 2561X1 involved less physician work than codes 24582 and 25620, because code 24582 includes manipulation and 25620 involves open treatment as opposed to 2561X1 which involves percutaneous approach and without manipulation. The RUC thought that the survey results were strong and seemed reasonable for the service provided. However, in order to maintain rank order within this family of codes, the RUC felt that the survey 25th percentile work RVU was more appropriate than the median. **The RUC recommends the survey 25th percentile work RVU of 7.25 for 2561X1.**

The RUC reviewed code 2561X2 *Open treatment of distal radial extraarticular fracture or epiphyseal separation, with internal fixation* and compared it to codes 25622 *Open treatment of ulnar styloid fracture* (work RVU=7.59) and 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* (work RVU=8.54). The RUC felt that code 2561X2 fell between the two codes referenced by the specialty society and although the survey results seem reasonable for the service

provided, in order to maintain rank order the RUC felt that the survey 25th percentile work RVU was more appropriate. **The RUC recommends the survey 25th percentile work RVU of 8.50 for 2561X2.**

The RUC reviewed code 2561X3 *Open treatment of distal radial intraarticular fracture or epiphyseal separation; with internal fixation of two fragments* and compared it to codes 25431 *Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone* (work RVU=10.42) and 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* (work RVU=8.54). The RUC felt that code 2561X3 involved less physician work than code 25431 but more physician work than code 25620. In order to maintain rank order within this family of codes, the RUC felt that the survey 25th percentile work RVU was more appropriate. **The RUC recommends the survey 25th percentile work RVU of 10.01 for 2561X3.**

The RUC reviewed code 2561X4 *Open treatment of distal radial intraarticular fracture or epiphyseal separation; with internal fixation of two fragments with internal fixation of three or more fragments* and compared it to codes 25431 *Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone* (work RVU=10.42) and 25620 *Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation* (work RVU=8.54). The RUC felt that code 2561X4 involves more physician work than codes 25431 and 25620. In order to maintain order within this family of codes, the RUC felt that the survey 25th percentile work RVU was more appropriate. **The RUC recommends the survey 25th percentile work RVU of 13.00 for 2561X4.**

Practice Expense
The RUC assessed and accepted the standard practice expense inputs for codes 2561X1, 2561X2, 2561X3 and 2561X4.

Total Colectomy (Tab 11)
Charles Mabry, MD, American College of Surgeons (ACS)
Guy Orangio, MD, American Society of Colon and Rectal Surgeons (ASCRS)
Charles Shoemaker, MD, American Society of General Surgeons (ASGS)

The CPT Editorial Panel deleted two existing codes and created two new codes to accurately describe current practice of performing total colectomy. These modifications to CPT are a result of a comprehensive review made by the

specialty society of all the colon and rectal procedures as part of the Five Year Review.

4415X1
The RUC compared key reference code 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy* (Work RVU=34.95) with new code 4415X1 *Colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, includes loop ileostomy and rectal mucosectomy, when performed* and noted that the surveyed code requires less intra-operative time than the reference code, 240 minutes and 300 minutes respectively, because the abdominal contents are exposed after laparotomy (ie, laparoscopy requires blind 3-D visualization). However, the length of hospital stay for 4451X1 is greater because open abdominal colon procedures develop a prolonged ileus, requiring nasogastric suctioning, prolonged intravenous fluids and delay in returning to oral intake. Because of the abdominal ileus causing distension and the long abdominal incision, the patient has difficulty with pulmonary function and ambulation. Atelectasis can develop requiring aggressive pulmonary care. In addition, the RUC noted that the surveyed pre-service times were over-estimated by the survey respondents. The RUC recommends that the pre-service evaluation and positioning time for 4415X1 be 30 minutes and 15 minutes, respectively as they felt these times appeared to be more appropriate. The survey median RVW of 33.00 is recommended for 445X1. This value results in an IWPUT of 0.075 that is correctly less than the laparoscopic reference procedure 44211 (IWPUT=0.081). **The RUC recommends 33.00 Work RVUs.**

4415X2
The RUC compared key reference code 44211 *Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy,* to new code 4415X2 *Colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy and rectal mucosectomy, when performed* requires less intra-operative time requires less intra-operative time because the abdominal contents are exposed after laparotomy (ie, laparoscopy requires blind 3-D visualization). However, the length of hospital stay for 4451X2 is greater because open abdominal colon procedures develop a prolonged ileus, requiring nasogastric suctioning, prolonged intravenous fluids and delay in returning to oral intake. Because of the abdominal ileus causing distension and the long abdominal incision, the patient has difficulty with pulmonary function and ambulation. Atelectasis can develop requiring aggressive pulmonary care. In addition, the RUC noted that the surveyed pre-service times were over-estimated by the survey respondents. The RUC recommends that the pre-service evaluation and positioning time for 4415X2 be 30 minutes and 15 minutes, respectively as they felt these times appeared to be more appropriate.

The survey median RVW of 34.00 is recommended for 445X2. This value results in an IWPUT of 0.073 that is correctly less than the laparoscopic reference procedure 44211 (IWPUT=0.081). **The RUC recommends 34.00 Work RVUs.**

Practice Expense

The standard inputs for 090 day global period codes only performed in the facility were applied with one exception: an additional 7 minutes was allocated to the first post-operative visit for the extra time required to care for stomas.

Interstitial Fiducial Marker Placement (Tab 12)

Jonathan Berlin, MD, American College of Radiology (ACR)
Thomas Cooper, MD, American Urological Association (AUA)
Geraldine McGinty, MD, American College of Radiology (ACR)
Najeeb Mohideen, MD, American Society for Therapeutic Radiology and Oncology (ASTRO)

The CPT Editorial Panel created a new code to report interstitial fiducial marker placement. Fiducial markers are a safe and appropriate device to verify and correct the position of the target organ and the amount of seed migration and organ deformation is far below current tumor delineation accuracy.

The RUC compared the surveyed code 558XX *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* to the reference code 76873 *Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning* (Work RVU=1.55). The specialty society made some revisions to the surveyed time as it was felt that the survey respondents over-estimated the pre-service work associated with this code. The specialty society recommends that the pre-service time inputs should be reduced to 19 minutes of pre-service evaluation time and no time should be allocated to scrub, dress and wait time as these actions do not occur for this procedure. The specialty society recommends that the median intra-service time of 20 minutes and 10 minutes of immediate post-service time is appropriate. Taking into account this modification in recommended physician time, the total service time for the surveyed code is virtually the same as the reference code, 59 minutes and 60 minutes respectively. However, the surveyed code has much higher intensity and complexity measures associated with it when compared to the reference code. Therefore, to account for this difference in intensity and complexity the specialty society recommends the 25th percentile of 1.73 RVUs. The RUC reviewed the survey data and felt that the 25th percentile work RVU, 1.73 RVUs, appropriately places this code in

comparison to the reference code. **The RUC recommends 1.73 work RVUs for 558XX**.

Practice Expense
The RUC reviewed the practice expense inputs recommended by the specialty society. Many of these inputs were amended to reflect standards set by the PEAC.

Laparoscopic Supracervical Hysterectomy (Tab 13)
George A. Hill, MD, American College of Obstetrics and Gynecology (ACOG)
Craig Sobolewski, MD, American College of Obstetrics and Gynecology (ACOG)
Pre-Facilitation Committee#3

The CPT Editorial Panel created four new codes to describe a laparoscopic approach of a total hysterectomy with the removal of the uterine fundus after morcellation.

The RUC reviewed code 585XX3 *Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less;* and the specialty society indicated that the survey median work RVU appeared to be high, however they felt that the survey appropriately assessed the amount of intra-service physician time associated with this procedure. The RUC reviewed the survey results and agreed that, although the RVU and pre-service time seemed to overestimate the work involved in this procedure, the intra-service physician time of 95 minutes was appropriate. The specialty society used the building block approach by using the low survey RVU of 14.17 or the reference service code, CPT code 58550 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less* (Work RVU= 14.17) minus 5 minutes of intra-service time and proposed a work RVU of 13.77 for code 585XX3 (14.17- 0.40=13.77). **The RUC recommends a work RVU of 13.77 for 585XX3.**

The RUC reviewed codes 585XX4 *Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)*, 585XX1 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams;* and 585XX2 *Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)* and felt that the mental effort and judgment, technical skill, physical effort and psychological stress intensity measures were similar to the reference service code 58552 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)* (Work RVU=15.98). In order to maintain rank order the RUC felt that the surveys 25th percentile work RVUs were appropriate. **The RUC recommends the 25th percentile survey median work RVUs of 15.63 for code 585XX4, 15.94 for code 585XX1 and 17.44 for 585XX2.**

The specialty society agreed that the pre-service time may have been overestimated by the survey respondents and felt that the post-service physician time should be the same for this family of codes (585XX1-585XX4). However, the specialty society agreed that the survey intra-service time accurately reflected the time involved in this procedure. Therefore, the specialty society adjusted the pre-service, immediate post-service time, and visits to all reflect the similarity of time for this family of codes in order to maintain rank order. The RUC also agreed that the changes in pre- and post-service time were appropriate. Each code in this family will have 45 minutes pre-service evaluation, 10 minutes pre-service positioning, 5 minutes pre-service scrub, dress and wait, 30 minutes immediate post-service time, two 99213 visits, one 99238 visit, one 99212 visit and two 99213 visits. The only variance is the intra-service time. **The RUC recommends the physician time below to maintain rank order in this family of codes.**

CPT Code	Pre-Service Eval	Pre-Service Positioning	Pre-Service Scrub, Dress, Wait	Intra-Service	Immediate Post-Service	Visits
585XX3	45	10	5	95	30	99231 x 2, 99238 x 1, 99212 x 1, and 99213 x 2
585XX4	45	10	5	110	30	99231 x 2, 99238 x 1, 99212 x 1, and 99213 x 2
585XX1	45	10	5	120	30	99231 x 2, 99238 x 1, 99212 x 1, and 99213 x 2
585XX2	45	10	5	135	30	99231 x 2, 99238 x 1, 99212 x 1, and 99213 x 2

Practice Expense

The RUC assessed and accepted the standard practice expense inputs for codes 585XX3, 585XX4, 585XX1 and 585XX2.

New Technology/Services List

As part of the new process established by the RUC for identifying new technology, these codes (585XX3, 585XX3, 585XX1 and 585XX2) have been identified as using new technology and will be flagged in the RUC database to return to the RUC for re-review once this technology has become widespread.

Ophthalmic Endoscope (Tab 14)

Stephen Kamenetzky, MD, American Academy of Ophthalmology (AAO)
Christopher Quinn, OD, American Optometric Association (AOA)

The CPT Editorial Panel requested that the RUC review codes 67036 *Vitrectomy, mechanical, pars plana approach;* and 67112 *Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy*

techniques to determine if separate reporting of 66990 *Use of ophthalmic endoscope (List separately in addition to code for primary procedure)(66990 may be used only with codes 65820, 65875, 65920, 66985, 66986, 67036, 67038, 67039, 67040, 67112)* impacts the work of codes 67036 and 67112. The RUC determined that codes 67036 and 67112 were initially valued prior to the use of an ophthalmic endoscope, therefore these two codes do not already include the use of an ophthalmic endoscope. The RUC determined that reporting 66990 in addition to 67036 or 67112 is appropriate. **The RUC determined that the revision to add-on code 66990 is editorial.**

MRI Functional Cortical and Subcortical Brain Mapping (Tab 15)
James Anthony, MD, American Academy of Neurology (AAN)
Robert Barr, MD American Society of Neuroradiology (ASNR)
Jonathan Berlin, MD, American College of Radiology (ACR)
Scott Faro, MD American Society of Neuroradiology (ASNR)
James Georgoulakis, PhD, American Psychological Association (APA)
John Hart, Jr., MD, American Academy of Neurology (AAN)
Geraldine McGinty, MD, American College of Radiology (ACR)
Stephen Rao, PhD, American Psychological Association (APA) – *disclosed financial interest prior to presentation.*
Pre-Facilitation Committee #2

The CPT Editorial Panel created three new functional MRI codes to describe performing magnetic resonance imaging on an active patient, which allows regional brain mapping of human cognitive functions such as motor skills, vision, language and memory. Functional MR localization of eloquent cortex is accomplished by imaging the active patient during specific task performance.

705X54 and 705X55

The RUC reviewed codes 705X54 *Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration* and 705X55 *Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing* and discussed that for these procedures a radiologist interprets the brain fMRI. For code 705X54, a technician, non-physician, or non-psychologist is performing the test and the radiologist is supervising the technician and for code 705X55, the radiologist is doing less supervisory work and the reduced amount of work that they are performing on the supervision side is outweighed by the increased number of images. In other words, there is decreased supervision but increased processing involved in the physician performing code 705X55.

In the pre-facilitation meeting the specialty society reduced the immediate post-service time to 10 minutes for code 705X54. The RUC agreed that this was appropriate since the surveyees may have misinterpreted some of the intra-service work as immediate post-service work and this time more accurately represents the physician time associated with this procedure. The RUC carefully reviewed the survey data for 705X54 to code 73223 *Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU=2.15 and intra-service time of 30 minutes). The RUC felt that the work RVU recommendation and physician time for 705X54 was consistent with the upper extremity joint MRI, code 73223. **The RUC recommends a work RVU of 2.11 for code 705X54.**

The RUC then compared code 705X55 to MRI codes 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU=2.36, 43 minutes of total time) and 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing* (work RVU=2.40, 45 minutes of intra-service time). The work RVUs for code 705X55 are consistent and the recommended work RVU and with the family of MRI codes (neck and brain). When performing code 705X55 the additional images must be taken into account, which would cause the work relative value to be more than the traditional brain MRI codes. In the pre-facilitation meeting the specialty society reduced the pre-service evaluation time to 10 minutes and reduced the immediate post-service time to 10 minutes for code 705X55. The RUC agreed with these changes in pre and post-service time, as this more accurately represents the physician times associated with this procedure. The specialty society computed the value by reducing the survey 25th percentile work RVU of 3.10, subtracted out 25 minutes that were taken out of the pre- and post-service time (0.0224*25=0.56) to come up with a work RVU of 2.54 (3.10-0.56=2.54). Given the relativity of this value to the value of the reference codes, the RUC agreed that the work value was appropriate. **The RUC recommends a work RVU of 2.54 for code 705X55.**

<u>9604X1</u>

The RUC reviewed code 9604X1 *Neurofunctional testing selection and administration during non-invasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report* and the specialty society indicated that the median survey time appeared to be high. The survey respondents indicated that the physical effort and psychological stress complexity measures were less for 9604X1 than the reference code 95958 *Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring* (work RVU=4.24). The

RUC then compared 9604X1 to code 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU=3.52, intra-service time=60 minutes). The RUC felt that the physician work and time involved to perform code 9604X1 was similar to that to perform code 95810. Therefore, the RUC recommends the 25th percentile work RVU of 3.43. Additionally, in the pre-facilitation meeting the specialty society reduced the pre-service evaluation time to 10 minutes and reduced the immediate post-service time to 10 minutes to accurately reflect the physician time involved in performing this procedure. The RUC agreed that pre- and post-service physician time changes were appropriate. **The RUC recommends the survey 25th percentile work RVU of 3.43 for code 9604X1.**

CPT Code	Pre-Eval	Pre-Positioning	Pre-Scrub	Intra-Service	Immed Post-Service	Work RVU
705X54	15	0	0	35	10	2.11
705X55	10	0	0	45	10	2.54
9604X1	10	0	0	60	10	3.43

Practice Expense

The RUC reviewed, modified and accepted the practice expense inputs for 705X54, 705X55 and 9604X1. A change was made to reduce the metal screening/interview time for code 705X54 from five minutes to two minutes. Another change was made to decrease all the pre-service facility times for code 9604X1, from three minutes to zero minutes because the pre-service activities are performed by the physician and this time is already captured.

New Technology/Services List

As part of the new process established by the RUC for identifying new technology, these codes (705X54, 705X55 and 9604X1) have been identified as utilizing new technology and will be flagged in the RUC database to return to the RUC for re-review once this technology has become widespread.

Sonographic Measurement of Nuchal Translucency (Tab 16)

George A. Hill, MD, American College of Obstetrics and Gynecology (ACOG)
James T. Christmas, MD, American College of Obstetrics and Gynecology (ACOG)

The CPT Editorial Panel created one new code and one add-on code to describe a more efficient and non-invasive risk assessment, which maximizes the detection rate of Down Syndrome and minimizes the screen positive rate at an early gestational age.

768XX1

The RUC reviewed code 768XX1 *Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation* and compared the work involved to that of a standard first trimester ultrasound, code 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU=0.99, global=XXX). The specialty society indicated that when performing a standard first trimester ultrasound, code 76801, in the majority of cases all of the elements are obtained without waiting for any anatomy to change or repositioning of the patient. When performing the standard first trimester ultrasound the crown/rump length is measured in virtually any orientation that the fetus is positioned in and at any magnification. Additionally, with code 76801, there is not a great deal of attention to the gain settings on the ultrasound machine. However, when measuring the nuchal translucency, code 768XX1, the embryo is between 4 to 8 centimeters in length, but the measurement of the nuchal translucency must be down to one-tenth of a millimeter. This precision requires absolutely perfect positioning of the embryo. The embryo must be transverse to the plane of the ultrasound beam, and there must be a perfect midsagittal view. Any movement of the cursors must not be more than a one-tenth millimeter increment and the fetus must be caught in a neutral position. Therefore, code 768XX1 was believed to be more complex than code 76801. The survey respondents supported the higher complexity by indicating that the mental effort and judgment, technical skill/physical effort and psychological stress intensity measures of 768XX1 are more complex than the intensity measures for code 76801. **The RUC recommends the survey median work RVU of 1.18 for code 768XX1.**

768XX2

The RUC reviewed code 768XX2 and the specialty society indicated that the survey median RVU appeared to be high. Therefore, the specialty society proposed the 25th percentile survey work RVU of 0.99 for code 768XX2. The RUC recognized that the intra-service time of 20 minutes for 768XX2 would be the same as the intra-service time for 768XX1, however, since 768XX2 is an add-on code to capture each additional gestation, there would not be any pre- or post-service time. The RUC also compared code 768XX2 to add-on codes 76810 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU=0.98, intra-service time = 20 minutes, global=ZZZ) and 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU=0.83, intra-service time = 10 minutes, global=ZZZ) and found the work RVU and intra-service times to be comparable. **The RUC**

recommends the 25th percentile survey work RVU of 0.99 for code 768XX2.

Practice Expense
The RUC assessed and modified the practice expenses for codes 768XX1 and 768XX2 to reflect standard inputs.

Computerized Corneal Topography (Tab 17)
Stephen Kamenetzky, MD, American Academy of Ophthalmology (AAO)
Christopher Quinn, OD, American Optometric Association (AOA)

The CPT Editorial Panel created a new code to describe computerized corneal topography a test which detects and monitors corneal changes due to disease or trauma. An estimate of corneal disease or trauma may be obtained with retinoscopy, which is part of the single eye exam or general ophthalmological services, however this is not similar to the detection provided with computerized corneal topography.

The RUC felt that the survey median times for code 92XXX were comparable to the reference service code 92135 *Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral* (work RVU=0.35). The RUC also indicated that the specialty society work relative value recommendation and survey median times for code 92XXX is comparable to codes 99260 *Ophthalmodynamometry* (work RVU=0.20) and 92370 *Repair and refitting spectacles; except for aphakia* (work RVU=0.32). **The RUC recommends the survey median work RVU of 0.35 for code 92XXX.**

Practice Expense
The RUC assessed and approved the practice expenses submitted for code 92XXX.

Exhaled Nitric Oxide Measurement (Tab 18)
Edward Diamond, MD American College of Chest Physicians (ACCP)
Alan Plummer, MD American College of Chest Physicians (ACCP)

The CPT Editorial Panel created a new code to report exhaled nitric oxide measurement, a procedure that non-invasively measures airway inflammation, i.e. the main cause of asthma. Exhaled nitric oxide measurement provides the physician with the means of evaluating an asthma patient's inflammatory status and response to anti-inflammatory therapy.

The RUC reviewed the specialty society's recommended practice expense inputs as this procedure has no physician work associated with it. The RUC

learned that this procedure would only be performed in the non-facility setting by a blend of RN/RT. **All of the submitted inputs were reviewed and were approved by the RUC.**

Whole Body Integumentary Photography (Tab 19)
American Academy of Dermatology (AAD)
Facilitation Committee #2

The CPT Editorial Panel created a new code to report whole body integumentary photography for skin cancer detection.

The RUC reviewed the specialty society recommended practice inputs for this procedure as this procedure has no physician work associated with it. The RUC learned that this procedure would be performed in the non-facility setting by a medical photography technician assisted by an MTA. The RUC noted that most of the specialty recommended inputs were PEAC standards. It was explained by the specialty society that positioning the patient required 15 minutes and performing the test required 15 minutes. It was also noted by the RUC that it required 13 minutes to process the images captured during the test. The RUC agreed with all of these time inputs. When reviewing the medical supplies, it was noted that typically the images are printed out on paper as well as on CD. Therefore, the RUC recommended both inputs. The RUC made various other modifications to the practice expense inputs including staff type and various supplies. **The RUC recommends the amended practice expense inputs.**

New Technology
As part of the new process established by the RUC for identifying new technology, this code has been identified as utilizing new technology and will be flagged in the RUC database to return to the RUC for re-review once this technology has become widespread.

XI. Practice Expense Review Committee Report (Tab 20)

The following issues concerning existing codes were addressed by the PERC and from CMS's November 2006 final rule for 2006:

1) 78350 - Site of Service Recommendation Request.
2) 78481, 78483, and 78465 – Change in Current Direct Inputs Request
3) 36475 and 36476 – Change in Direct Inputs Request
4) 36566 – Change in Current Direct Inputs Request

5) Payment for Splint and Casting Reporting

New and Revised PE Input Recommendations
The PERC reviewed all the direct practice expense inputs for the new and revised codes brought forward for RUC review at this meeting**. The RUC approved the PERC report and it is attached to these minutes.**

XII. RUC HCPAC Review Board (Tab 21)

Mary Foto, OTR briefed the RUC on the HCPAC Review Board meeting conducted on February 2, 2006. Ms. Foto indicated that CMS provided an informative update on the Physical Therapy (PT)/Speech-Language Pathology (SLP) and outpatient Occupational Therapy (OT) services capitation, the chiropractic demonstration, Medical Nutrition Therapy (MNT) telemedicine codes in effect, and the low vision demonstration.

Ms. Foto informed the RUC that Emily Hill, PA-C, briefed the HCPAC that the NUCC has revised the 1500 Health Insurance Claim Form, primarily to include the National Provider Identifier (NPI) and ensure proper electronic claim submissions. This revised form will be effective February 1, 2007.

Ms. Foto informed the RUC that the PLI premium data collection that the HCPAC has been working on gathering is now complete, since the American Optometric Association has provided the HCPAC with its average annual PLI premium range for optometrists. **The HCPAC will send a letter to CMS providing this PLI premium information.**

Staff Note: A letter was sent on February 27, 2006, and is attached to these minutes.

Ms. Foto stated that the HCPAC discussed the psychological testing codes (96101-96103 and 96116-96120) since there has been some confusion by carriers on the appropriate method to code the technician and computer-administered psychological testing and neuropsychological testing codes. The HCPAC reaffirmed that the supervision as well as interpretation and report, as performed by a qualified health care professional (e.g., a physician or psychologist) are included in the technician and computer administered testing codes. The American Psychological Association indicated that they will submit editorial introductory language for the psychological and neuropsychological testing codes to CPT in order to clarify coding issues with these codes. AMA RUC HCPAC Staff indicated that she will work with CPT Staff to indicate proper coding procedures in the CPT Assistant.

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

XIII. Administrative Subcommittee (Tab 22)

Conflict of Interest/Financial Disclosure Statement
Doctor Richard Tuck briefed the RUC on the issues discussed at the Administrative Subcommittee meeting. Doctor Tuck informed the RUC that the Administrative Subcommittee reviewed the conflict of interest policy and financial disclosure statement. The Subcommittee felt that RUC members, alternates and advisors should indicate a conflict or disclose if a family member has an interest in any issues discussed/presented at the RUC. **The Administrative Subcommittee requested that the conflict of interest policy and statement, as well as the financial disclosure statement include disclosing whether a representative or "family member" has a financial interest.**

Additionally, the Administrative Subcommittee requested that two procedural steps occur in the RUC process to allow conflicts and financial interests to be made apparent to the RUC.

1. **All RUC members' and alternate members' conflict of interest statements should be disclosed in writing prior to RUC meetings and placed in the agenda book.**
2. **Each presenter verbally confirms any financial interests or lack of financial interests prior to the presentation of each issue/tab.**

The RUC discussed whether those with a declared interest should be allowed to continue to present. **The RUC concluded that the Administrative Subcommittee should discuss this issue at the April 2006 meeting.**

Re-review of New Technology/Services
Doctor Tuck informed the RUC that the Administrative Subcommittee determined that new evolving technology/services should be identified and re-reviewed at a time certain. The Subcommittee requested the following:

- **A check box is added to the RUC survey instrument and summary of recommendation form so that specialty societies/survey respondents may indicate if a new or revised code is considered to be a new technology service.**

- **At each RUC meeting there is a vote on each new and revised code to determine if a code is to be considered a new technology service.**
- **All new technology/services will be placed on the "New Technology/Service List" to be collated and maintained by RUC staff.**
- **The RUC would intend that all services on this list would be reviewed again at some time certain.**
- **The Administrative Subcommittee will discuss a timeline and other processes related to this at the April 2006 meeting.**

Confidentiality and Proprietary Rights

Doctor Tuck briefed the RUC that although AMA staff provides the Rules and Procedures document and the RUC Chair, Doctor Rich, reiterates the confidentiality and proprietary rights that all information discussed and materials provided by the AMA or the RUC are proprietary, there continues to be occasional infringements of this rule. Doctor Rich charged the Administrative Subcommittee with reviewing/developing a penalization policy. Discussion ensued as to whether the infraction would be deliberate or inadvertent, with a major or minor consequence. **The Administrative Subcommittee recommends that the RUC follow Section VII. Continued Representation of the Structure and Functions and any enforcement and appropriate penalties on violation of this section are to be determined by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).**

Five-Year Review Subcommittee

Doctor Tuck informed the RUC that based on recent MedPAC discussions and the RUC's mission to ensure correct valuation of all codes, the Administrative Subcommittee discussed that there should be a process to identify potentially misvalued codes. **The Administrative Subcommittee recommended that the RUC develop a new committee to identify potential misvalued codes for the Five-Year Review.**

Definition of Physician Work

Doctor Tuck stated that in discussing the difficulty to value potentially misvalued codes, a Subcommittee member noted that physician time to perform certain services may decrease due to new evolving technology, benefit to the patient, and ultimately provide cost savings to the overall health care system. A discussion then ensued regarding the RBRVS and the definition of physician work. There was general consensus that the RUC should study the current environment regarding quality measures, efficiency, and value to the patient and health care system.

A number of RUC members indicated that although the initial concepts on how to incorporate value to healthcare may be difficult, there is probably no better group than the RUC and CPT physicians to look at how quality

interacts with the payment system. If the RUC does not take part in this there are many other entities that will. This method will not come quickly or easily but the RUC should be involved otherwise we will have to deal with such a system that is inevitable without having a say in it. The RUC should be involved in the beginning framework of such a system. It was discussed that perhaps the RUC should add something in our mission statement to consider these ideas and how we would implement them is what we need to find.

The Administrative Subcommittee recommends that the RUC study additional mechanisms for evaluating physician work to include quality measures, efficiency, and value to the patient and health care system, while recognizing that no metric is currently available.

Verification of Accurate Data

Doctor Tuck informed the RUC that the Administrative Subcommittee discussed that due to various individuals involved in developing specialty society RUC surveys and the summary of recommendation forms submitted to the RUC, verification of the accuracy and integrity of the data to the RUC should occur. **The RUC recommends that RUC Advisors sign a statement to attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of the RUC Advisor's knowledge. RUC Advisors acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).**

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

XIV. Pre-Time Workgroup (Tab 23)

The RUC has created standards to the typical direct practice expense inputs: clinical labor activities, supplies, and equipment. These standards continue to be applied during each PERC meeting, and assist members in the development of direct inputs for the typical patient encounter. The Pre-Time Workgroup had been charged with creating discussion and making a recommendation to the RUC regarding the standardization of physician pre-service time.

The Workgroup members believed that in order to establish some standardization they would have to establish criteria. Benchmarks could be established based on some characteristics of the procedures. In addition, members warned that if a benchmark is developed, as in the PEAC where 090 day global codes were set at 60 minutes of pre-service time, a bar is set, and all codes going forward would likely be set at that time or higher.

The Workgroup and RUC agreed to:

- Establish packages according to the specific details of the services provided
- These details would then make up the services in each package within or among each global period.
- At the next Five Year Review, the RUC may be able to retrospectively slot existing codes into their proper pre-service package with the assistance of the specialty society

The workgroup and RUC believed that small groups of RUC members, representing surgical and non-surgical specialties, could meet to initially establish the packages for each global period. It was suggested that AMA staff send a letter to all specialties requesting a list of what they view as pre-service physician work activities. These lists would be compiled and discussed by the established groups who would then determine the initial packages.

In addition, the workgroup asked for AMA staff to graph the existing time data in order to identify any groupings within the global periods, and report back to the group at the next meeting.

The Pre-Time Workgroup report was approved and is attached to these minutes.

XV. Practice Expense Subcommittee (Tab 24)

Doctor Trexler Topping briefed the RUC on issues discussed at the PE Subcommittee. The following issues were discussed:

Indirect Practice Expense Allocation
In the year 2000, the AMA Socioeconomic Monitoring Survey (SMS), which included questions related to physician practice expense, was discontinued. This data are now dated yet still are used by CMS in their practice expense methodology to develop practice expense relative values. The RUC and the AMA's Health Policy Group have continued to seek funding and approval for additional surveys, as there is a significant need for more current data.

Subcommittee members believed that the specialties would be interested in working with the AMA, through the RUC process to design and financially support the survey. It was noted that the survey could be used for not only capturing current practice expense data, but also information on practice liability insurance premiums, and on the overall increase in physician practice expense for use in organized medicine's campaign to replace the SGR.
The Subcommittee and RUC agreed that a multi-specialty survey should be pursued and recommended that: **The RUC reaffirms the RUC's November 3, 2004 letter to Doctor Michael Maves that states "We would offer and**

encourage the AMA to work through the RUC to involve the specialties in both constructing the survey and funding the effort."

Standardized 090 and 010 Day Global Period Codes and Medical Supplies
CMS representatives again informed the RUC that they intend to apply the standard packages associated with 090 day global codes for the 2007 physician fee schedule. The original CPEP data may have contained some specialty-specific supply items but these items would be replaced with the standard packages. In some cases the supplies may be appropriate but since specialties have not asked for any exceptions to standard, CMS has no way of retaining these items. If CMS changes its practice expense methodology from top down to bottom up and applies the RUC's recommendation for these codes, there may be an adverse affect on the RVUs for some specialty specific codes.

The RUC recommended the following:
AMA staff will provide specialties with a list of CPT codes where there may be specialty-specific supply or equipment items earmarked for deletion when the 010 day and 090 day standard packages are applied by CMS.

Future Refinement of Direct Practice Expense
This Subcommittee has discussed the future refinement of direct practice expense inputs regarding mechanisms to review services moving into the office setting and for ideas related to the first 5 Year Review of the direct inputs. The Subcommittee continued to discuss these issues in order to establish future RUC policy.

The RUC should conduct a review of the practice expense direct inputs going forward and will outline a process for such review as CMS determines when such review processes should begin.

Equipment Utilization Assumptions
When CMS developed its practice expense methodology it had to make an assumption of the equipment utilization because the data was not collected in the Abt study. CMS has made blanket equipment assumptions for hundreds of equipment items over the years which either overstates the utilization for some or underestimates equipment costs for others. The Subcommittee discussed whether the RUC is interested in studying equipment utilization in an effort to recommend accurate assumptions to CMS. The Subcommittee discussed the possibility of creating a tiered utilization schedule for the various equipment types but realized the task was overwhelming. The Subcommittee will continue to monitor CMS's equipment utilization assumptions carefully for new methodological approaches and reexamine them at a later date.

XVI. Research Subcommittee (Tab 25)

Doctor Cohen presented the Administrative Subcommittee Report to the RUC. Doctor Cohen announced that at recent RUC meetings there have been several discussions held by RUC members that there was a need for a comprehensive review of the RUC Survey Instrument and Summary of Recommendation Form. Several suggestions were made during these discussions regarding what needed to be reviewed. The following is a list of actions the RUC made to modify the survey instrument, summary of recommendation form and corresponding instruction document:

- **The RUC recommends adding a table to summarize the specialty society recommended data to the summary of recommendation form.**

- **The RUC recommends adding the prolonged services CPT codes to the survey instrument. Doctor Cohen asked Doctors Hollmann, Manaker and Przybylski to review the explanatory note after drafted by RUC Staff.**

- **The RUC recommends that a note be incorporated in the instruction document stating that RUC members and RUC Alternates are prohibited from participating in their associated specialty society's surveys as part of RUC policy that RUC members do not act as advocates for their specialties.**

Furthermore, a suggestion was made to add the percent of respondents who have performed the surveyed procedure in the last 12 months to the summary form. This question is currently on the survey instrument but not on the summary form. The question was originally added to assist specialty societies in developing their recommendations.

The Research Subcommittee discussed this issue and determined that not only is the information provided about a survey respondent's performance of the surveyed procedure within the last 12 months not necessary to include on the summary of recommendation form but because the information provided by this question was not instrumental in valuing a new or revised CPT code this question should be removed from the survey instrument. The Research Subcommittee recommends that the following question be removed from the survey instrument:

QUESTION 5: How many times have you personally performed these procedures in the past year?
New/Revised Code: _____ Reference Service Code: _____

The RUC discussed this issue and disagreed with the Research Subcommittee's action to delete this question entirely from the RUC survey instrument because the specialty societies find the information from this question to be very useful when calculating their specialty society recommendations. **The RUC recommends maintaining Question 5 on the RUC survey instrument.**

In addition to these items, at the request of the Research Subcommittee Chair, an e-mail was sent to RUC participants to provide their input on items to be added to this agenda item. Eight responses were received. The following is a list of actions the RUC made to modify the survey instrument, summary of recommendation form and corresponding instruction document :

- **The RUC recommends placing question 7 *Is your typical patient for this procedure similar to the typical patient described on the cover* directly following the vignette on the RUC survey instruments**
- **The RUC recommends removing from the survey instrument questions regarding, address, fax number and years of practice within a specialty.**
- **The RUC recommends that only the information directly pertaining to the global period of the surveyed code should remain on the associated survey instrument.**
- **The RUC recommends that the term "Conscious Sedation," should be replaced with the current term "Moderate Sedation" on the RUC survey instruments**
- **The RUC recommends that on the summary of recommendation form, a field should be added to designate whether reference codes utilize RUC or Harvard times as this would assist the RUC in its discussions pertaining to physician times.**

Doctor Cohen mentioned that there were several issues that still needed to be addressed by the Research Subcommittee and subsequently by the RUC including 1.) a recommendation from the AGA and the ASGE was that the RUC needs to recognize the discharge day planning activities for 000 day global periods and 2.) standardized descriptions of service for XXX codes. The Research Subcommittee recommended and the RUC agreed these issues be placed on the April 2006 Research Subcommittee Agenda.

Furthermore, there were also various suggestions made by respondents regarding the basic format of the survey instrument and issues concerning the availability of having the survey process completely maintained online. RUC staff will create an entirely new format for the survey instruments based on the discussions held by the Research Subcommittee as well as suggestions and comments received and present this updated survey instrument at the April RUC Meeting. In addition, RUC staff is in communication with the AMA

Surveying Experts to examine the possibilities available to the RUC in conducting its survey process online.

During the discussion of the survey instruments, summary of recommendations forms and corresponding instruction document, the American College of Surgeons discussed a letter they had submitted outlining a general discussion of the RUC survey process. The College expressed concern that the specialty survey process be studied to ensure that it remains based on magnitude estimation and not merely a "social survey" collecting the specialties' "wish list." **The RUC recommends that as a first step, AMA Staff prepare an analysis of survey medians, specialty recommendations, RUC recommendations and CMS' final implemented relative values to see if the relationship between the survey medians and the final value has changed throughout the process.**

In addition to reviewing the summary of recommendation form and the survey instrument, there was also a request to review the current reference service list policy. Doctor Cohen announced that RUC Staff will be providing the Research Subcommittee historical and background documents pertaining to this issue and postponed discussion of this issue to the April RUC Meeting

Doctor Cohen updated the RUC about developments with the Modifer-51 workgroup. At the October 2005 RUC Meeting, there was a discussion related to the processes in place for determining which codes are exempt from the use of Modifier -51 as listed in Appendix E of the CPT book. It was recommended to the CPT Editorial Panel that this issue be discussed to consider establishing a process to allow each of the codes listed in Appendix E to be reviewed for appropriateness using a set of criteria to determine whether the value assigned warrants its exemption from the Modifier -51. The CPT Editorial Panel has created a Modifier Workgroup which will review each code currently given the Modifier -51 exemption to determine its appropriateness of being on the list and to establish criteria that would determine how future codes would be placed on this list i.e., confirming with RUC Staff that pre- and post-service times are not associated with the proposed codes. The Workgroup has asked for RUC participation. Four members of the Research Subcommittee have volunteered to participate in these meetings: Doctors Derr, Hitzeman, Manaker and Peter Smith. The Workgroup will be meeting during the CPT Meeting February 9-12, 2006. RUC members will be able to participate via conference call. The Research Subcommittee requests a report from the Subcommittee members participating on the call as to the actions items taken by the Workgroup.

XVII. Professional Liability Insurance Workgroup (Tab 26)

Doctor Hitzeman provided the RUC with a brief on what was discussed at the PLI Workgroup meeting. Doctor Hitzeman informed the RUC that CMS has agreed to examine specific malpractice premium data for use in the calculation of the Malpractice Geographic Practice Cost Index (GPCI) which will be made available by Doctor Stephen Kamenetzky. Doctor Kamenetzky indicated to AMA staff that he will begin to assemble the data from the Physician Insurers Association of America (PIAA) for the six pilot states (Iowa, Colorado, New York, Florida, Pennsylvania and Texas) that have been chosen. Doctor Kamenetzky indicated that he should be able to obtain this data for CMS in approximately 90 days.

Doctor Hitzeman indicated that the PLI Workgroup felt that the RUC's previous recommendation to CMS regarding low volume codes should be reinforced. Therefore, **the PLI Workgroup recommends that the RUC reaffirm our previous recommendation to CMS that CMS utilize these recommended specialties for low volume codes (ie, fewer than 100 claims per year), rather than rely on claims data.**

Staff Note: A letter was sent to CMS on February 27, 2006, and is attached to these minutes.

Doctor Hitzeman informed the RUC that the PLI Workgroup reviewed the professional liability insurance information section of the Instructions for Specialty Societies Developing Recommendations (page 10). The Workgroup noted that while CMS methodology utilizes physician work and the specialty risk factor to drive PLI relative values, the work RVU may not always be the best surrogate for a crosswalk. Other measures such as intra-service work may be more appropriate. **The PLI Workgroup recommends that the instructions be refined to include "other measures."**

The PLI Workgroup also reviewed the professional liability insurance information section of the summary of recommendation form (page 5). The PLI Workgroup recommends that further directions be provided on the determination of surgical versus non-surgical risk factors so that specialties understand the distinction as defined by CMS.

Doctor Hitzeman informed the RUC that the Workgroup agreed that CMS should request physicians to provide PLI premium information on an annual basis. However, the full RUC did not accept this recommendation.

Doctor Hitzeman informed the RUC that the Workgroup discussed the probability of a multi-specialty endeavor to gather PLI premium information. Specifically, with the implementation of National Provider Identifiers (NPIs) such collection efforts may be possible directly through CMS. The Workgroup continued to discuss that it would be helpful for CMS to identify the key elements CMS would require to use in their PLI methodology.

The PLI Workgroup also discussed the possibility of gathering PLI information as part of the PE multi-specialty survey process if it occurs.

The PLI Workgroup Report was approved and is attached those these minutes.

XVIII. Other Issues

Society of Thoracic Surgeons (STS) Request

The Society of Thoracic Surgeons (STS) requested that the RUC retract their recommendation that a parenthetical be added to the 2006 CPT book indicating that codes 33925 *Repair of pulmonary artery arborization anomalies by unifocalization; without cardiopulmonary bypass* and 33926 *Repair of pulmonary artery arborization anomalies by unifocalization; with cardiopulmonary bypass* should not be reported together with code 33697 *Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect*.

The STS indicated that the parenthetical note included in the 2006 CPT book under codes 33925 and 33926 indicating (Do not report 33925, 33926 in conjunction with 33697) is inappropriate. The parenthetical note did not exist under codes 33918 and 33919, which were deleted and replaced with the new codes due to the descriptor changes to the codes, nor were they previously bundled under the NCCI. As a result of this parenthetical note, CMS had bundled procedures 33925 and 33926 with 33697 with a "0" indicator which means that the codes can never be reported together.

The STS believes that the parenthetical note that does not allow 33697 to be reported in conjunction with code 33925 or 33926 is inappropriate. It is not always necessary to do both procedures. However, if both procedures are performed in the same session, unifocalization requires more work in addition to tetralogy of Fallot repair. The abnormal pulmonary arteries need to be dissected from their source (typically the descending aorta but also the brachiocephalic vessels) and then incorporated with the native pulmonary arteries. Occasionally, this could involve a separate thoracotomy during the same anesthetic with unifocalization, then repair of tetralogy of Fallot through a sternotomy.

In reviewing this issue, **the RUC believes that the parenthetical note under CPT codes 33925 and 33926 should be deleted. The RUC communicated this to the CPT Editorial Panel.**

The meeting adjourned on Saturday, February 4, 2006 at 4:35 p.m.

AMA/Specialty Society RVS Update Process
Practice Expense Review Committee
February 2, 2006

The following PERC members participated in the discussions: Doctors Moran (Chair), Anthony, Brill, Cerqueira, Cohen, Felger, Hollmann, McCrieght, J. Regan, and Ouzonian.

Doctor Moran welcomed and informed the group that they were on a tight time schedule. Doctor Ken Simon from CMS provided an update of the agency's recent activities. Doctor Simon stated that the agency is continuing its work on pay for performance initiatives and that it will be a reality in 2007. Doctor Simon stressed the need for medicine to monitor CMS's work on pay for performance. In addition, it was mentioned that CMS will be having a Town Hall meeting on CMS's practice expense methodology on Wednesday, February 15, 2006 in Baltimore. You must register for the meeting, but it is open to all.

The following issues were addressed from CMS's final rule for 2006:

6) <u>78350 - Site of Service Recommendation Request: SNM, ACR, (AAFP to comment):</u>
In November 2006 CMS reported that they had received comments from one specialty society disagreeing with the RUC's recommendation for code 78350, *single photon bone densitometry.* The specialty stated they believed that the procedure is being performed in the office and provided direct inputs for review. The PERC and the specialty society carefully reviewed the inputs, made reductions to the inputs and its reference code, and then accepted the recommendation.

7) <u>78481, 78483, and 78465 – Change in Current Direct Inputs Request: SNM, ACR, ACC</u>
Two years ago at the January 2004 PERC meeting, the PERC made a full review of the direct practice expense inputs of codes 78481 *Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification* and code 78483 *Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification*

In November 2005, CMS reported that they received a comment from an equipment distributor and multiple comments from physicians asking them to add more clinical labor supplies and equipment to codes 78481 and 78483. The commenters emphasized that the labor costs are understated, and that additional supplies and equipment are necessary to perform these services. In particular, the commenters requested" CMS "add a nuclear medicine gamma camera to the equipment inputs or cross-walk the equipment listed for CPT 78465 *Myocardial perfusion imaging;tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification.* The nuclear medicine gamma camera distributor presented supply and equipment tables for both codes to CMS, using direct PE inputs currently listed in the PE database, most of these inputs are found in the PE for CPT 78465.

The PERC was informed by the specialty that the codes when first presented to the PEAC the codes were understood to be add on codes, however later they realized that they were more typically performed as stand alone codes. After this was clarified the PERC reviewed the specialty recommendation, made minor changes, and accepted them.

8) 36475 and 36476 – Change in Direct Inputs Request: SIR, ACR, SVS

In February 2004 the RUC made recommendations for physician work and practice expense for the then new CPT codes 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* and add on code 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency;second and subsequent veins treated in a single extremity, each through separate access sites.*

In November 2005, CMS reported that, a manufacturer requested that CMS "add 15 minutes of clinical labor and a tilt table to the PE database for CPT codes 36475 and 36476—both new codes for CPT 2005." The specialty requested to add a tilt table to the entire family of ablation codes (36475, 36476, 36478, 36479), but did not believe an additional 15 minutes was warranted. The PERC concurred and recommends the addition of a tilt table to each code.

9) 36566 – Change in Current Direct Inputs Request: SIR

In April 2003, the RUC made recommendations for physician work and practice expense for the then new code 36566 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (For peripherally inserted non-tunneled central venous catheter, age 5 years or older, use 36569).

In November, 2005 CMS reported that a specialty society and a manufacturer had asked to replace the supply item, a Tesio type dual catheter, with the Lifesite system. It is explained that the manufacturer asked the CMS for assistance in correcting a "clerical error". The commenters explain that "CPT codes 36565 and 36566 are nearly identical in procedure, although CPT 36566 requires the insertion of "subcutaneous port(s)" and the Tesio-type catheter, priced at $355, is currently listed in both these procedures." The Lifesite system, containing a subcutaneous port, is priced at $1,750. Both commenters noted that 2 Lifesite systems are necessary to perform this procedure instead of one for a total supply cost of $3,500.

At its previous meeting, the RUC had asked CMS to monitor on an annual basis high priced disposable medical supplies, as they continually create disruptions in the PE RVUs of other procedures when applied to CMS's PE methodology. CMS reported that this was on there radar screen but has not implemented any mechanism to review such items. The PERC again stressed the need for such review that only applied to items priced over $200.

The PERC was informed that there is only one manufacturer of the expensive supply being requested for inclusion in code 36566 at this time, but would expect competitors to have another device that may be less expensive in the future. The PERC accepted the recommendation however suggested that this code be re-reviewed at a later date. The PERC also believed that a "tickler file" could be developed and maintained that would keep track of these special procedures with high priced disposables. Who would maintain this file was not determined. Doctor Brill was concerned that if CMS could update current marketplace prices connected with the outpatient prospective payment system, why isn't there a process for updating high priced disposables connected with Part B? The PERC members suggested the RUC's PE Subcommittee develop a formal methodology for this process.

10) 19298 and 19296 – Change in Direct Inputs Request: PERC Review

The Final Rule CMS stated the following, regarding concerning codes 19296 and 19298: "we received comments from a specialty organization citing that the total RVUs for CPT code 19298 are too low in comparison to those for CPT code19296—both new CPT codes for CY 2005. The specialty believes this difference is likely due to the supply PE inputs necessary to perform each procedure. The specialty states that the catheter supply expenses should be similar between the two services, yet the non-facility PE RVUs for CPT code 19298 (39.56 for CY 2005 and 42.28 for CY 2006) are significantly lower than those listed for CPT code19296 (117.96 for CY 2005 and 125.75 for CY 2006). The specialty stated that while the average number of catheters used for CPT code 19298 is 25, ranging from 15–30, this cost should be comparable to the catheter required for CPT code 19296. Finally, the specialty requests that CMS crosswalk the total RVUs for the non-facility setting from CPT code 19296 to CPT code 19298 for 2006 while they gather detailed information to present to them.

This issue was discussed by the PERC as a whole since no specialty had come forward with a formal recommendation. The PERC took no action on this issue.

11) Payment for Splint and Casting Supplies: APMA, AAOS, ASSH (ASPS, AAFP, AADA) to comment.

On November 1, 2000, CMS stated they had removed cast and splint supplies from the PE database for the CPT codes for fracture management and cast/strapping application procedures. Because casting supplies could be separately billed using Healthcare Common Procedure Coding System (HCPCS) codes, CMS did not want to make duplicate payment under for these items. However, in limiting payment of these supplies to the HCPCS codes Q4001 through Q4051, CMS unintentionally prohibited remuneration for these supplies when they are not used for reduction of a fracture or dislocation, but rather, are provided (and covered) as incident to a physician's service.

In June 2005, CMS proposed to eliminate the separate HCPCS codes for these casting supplies and to again include these supplies in the PE database. This would allow for payment for these supplies while ensuring that no duplicate payments are made. In addition, by bundling the cost of the cast and splint supplies into the PE component of the applicable procedure codes under the PFS, physicians would no longer need to bill Q-codes in addition to the procedure codes to be paid for these materials. Because these supplies were removed from the PE database prior to the refinement of these services by the PEAC, CMS proposed to add back the original CPEP supply data for casts and splints to each applicable CPT code and CMS requested that the relevant medical societies review the direct practice expense inputs and provide feedback regarding the appropriateness of the type and amount of casting and splinting supplies. CMS also requested specific information about the amount of casting supplies needed for the 10-day and 90-day global procedures, because these supplies may not be required at each follow-up visit; therefore, the number of follow-up visits may not reflect the typical number of cast changes required for each service.

The cast and splint supplies were added, where applicable, to the following CPT codes:
23500 through 23680
24500 through 24685,
25500 through 25695
26600 through 26785
27500 through 27566

27750 through 27848
28400 through 28675
29000 through 29750.

In CY 2007, CMS will pay for splint and cast through the PE component of the PFS and no longer make separate payment for these items using the HCPCS Q-codes.

The PERC held a conference call for Thursday, January 26th and discussed the direct inputs for these codes. On the conference call and at the PERC meeting, Doctor Ouzounian led the group discussion and presented the specialty's recommendation. The PERC understood the specialty's recommendation methodology and agreed with the recommended inputs.

New and Revised PE Input Recommendations
The PERC reviewed all the direct practice expense inputs for the new and revised codes brought forward for RUC review at this meeting. For a few issues involving codes performed only in the facility setting, where the standard 090 day package was recommended, there was no specialty representation. The PERC requests that in the future if there will be no specialty representation, that this is communicated to staff and written in the cover of the specialty's practice expense recommendations. The following issues and related practice expense inputs were reviewed and are recommended by the PERC:

Relative Value Recommendations for *CPT 2007*:

Lumbar Arthoroplasty (228X1 – 228X5)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Distal Radius Fracture (2561X1-2561X4)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Gastric Antrum Neurostimulation (436X1 – 439X4; 64590, 64595; 95970 – 95973)
The specialty indicated that there were only editorial changes to these codes and that the current practice expense inputs should be maintained. The specialty did not provide a listing of the current inputs however the PERC on this understanding, approved no change in the current inputs for these codes. *Tab 10 code was referred to CPT for further discussion.*

Total Colectomy (4415X1 – 4415X2)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Interstitial Fiducial Marker Placement (558XX)
The PERC and the specialty agreed on several reductions to the recommended practice expense inputs for these codes. CMS representatives stated that they were considering a global period change for this code to a 010 day global designation.

Laparoscopic Supracervical Hysterectomy (585XX3-585XX4; 58XX1, and 58XX2)
The PERC and specialty agreed on the standard 090 day global package for these codes.

Ophthalmic Endoscope (66990)
This code was removed from the agenda by the specialty.

MRI Functional Cortical and Subcortical Brain Mapping (705X54, 705X55, and 9604X1)
The PERC and specialty agreed to make minor changes to the clinical labor direct inputs for these codes.
Sonographic Measurement of Nuchal Translucency (768XX1 – 768XX2)
The PERC and specialty agreed to make minor changes to the clinical labor and equipment direct inputs for these codes.
Computerized Corneal Topography (92XXX)
The PERC accepted the recommended direct practice expense inputs for this code without modification.
Exhaled Nitric Oxide Measurement (950XX)
The PERC accepted the recommended direct practice expense inputs for this code without modification.

Whole Body Integumentary Photography (969XX)
The PERC and the specialty agreed to make minor changes in clinical labor and several changes to the equipment for this code.

The PERC meeting was adjourned at 10:50 am

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
February 2, 2006

Members Present:

Richard Whitten, MD, Chair	Emily H. Hill, PA-C
Mary Foto, OTR, Co-Chair	Christopher Quinn, OD
Thomas Felger, MD	Lloyd Smith, DPM
Robert Fifer, PhD	Doris Tomer, LCSW
James Georgoulakis, PhD	Arthur Traugott, MD
Anthony Hamm, DC	Jane White, PhD, RD, FADA

I. Welcome

Mary Foto, OTR, welcomed Thomas Felger, MD, who will serve as the RUC representative on the HCPAC.

II. CMS Update

Pam West, PT, DPT, MPH, provided a CMS update, informing the HCPAC on the following:

- *Physical Therapy (PT)/Speech-language pathology (SLP) and outpatient occupational therapy (OT) services capitation.* Dr. West informed the HCPAC that the PT/SLP and OT therapy capitation of $1,740 went into effect January 1, 2006. Dr. West also indicated that CMS is considering mechanisms to promptly implement a provision of the Deficit Reduction Act (DRA) that permits medically necessary therapy services exemptions from the therapy capitations.

- *Chiropractic demonstration.* Dr. West indicated that SLP/PT services performed by chiropractors under the demonstration will be included under the SLP/PT capitation, as appropriate. Dr. West and Anthony Hamm, DC, American Chiropractic Association, have indicated that the Chiropractic demonstration is currently running smoothly.

- *Medical Nutrition Therapy (MNT) telemedicine.* Dr. West informed the HCPAC that CMS has added three MNT codes (G0270 *Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face- to- face with the patient, each 15 minutes*, 97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes* and 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*) to the list of Medicare telehealth services, which went into effect January 1, 2006. Dr. West indicated that contractors have until April 3, 2006, to ensure that the GT modifier, which identifies telehealth services, is processed correctly.

- *Low vision demonstration.* Dr. West informed the HCPAC that the low vision demonstration is slated to begin April 3, 2006, which will involve payment to three types

of low vision specialists and occupational therapists. These demonstration services will not be subject to the OT therapy capitation.

III. Update on National Uniform Claim Committee (NUCC) Issues

Emily Hill, PA-C, American Academy of Physician Assistants, briefed the RUC that the NUCC has revised the 1500 Health Insurance Claim Form primarily to include the National Provider Identifier (NPI) and ensure proper electronic claim submissions. The form may undergo minor revisions and will be effective February 1, 2007.

IV. Other Issues

PLI Premium Data

Ms. Foto informed the HCPAC that the American Optometric Association has provided the HCPAC with its average annual PLI premium range for optometrists, which is $500 to $2,000. Previously, CMS indicated in the 2004 November 15 *Final Rule* that the agency was interested in RUC input on the appropriateness of the PLI crosswalk assumptions. The risk factors are currently set at the all physician risk factor for the professions indicated below. The RUC requested the PLI risk factor be set to 1.00 ($6,100) for the following eight health professionals and that CMS investigate other data as $6,100 most likely over estimates the PLI premium for these professions. The RUC also invited these professions to present evidence that their annual PLI premiums are greater than $6,100. These professions include:

- Clinical Psychologist
- Licensed Clinical Social Worker
- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

At the September 2005 meeting, the HCPAC professions submitted PLI premium data to the HCPAC, except opticians/optometry. Subsequently, at the September 2005 HCPAC meeting the dieticians also shared their PLI premium data. **The HCPAC believes that the yearly average PLI premium data per profession is accurate and will submit new premium data for opticians/optometry to CMS.**

Specialty Society	Average Yearly Premium	Yearly Premium Range
American Chiropractic Association	$1,870 (in 2005)	Up to $4,000 - $6,000 (New York averages $4,000 and Florida $6,000)
American Occupational Therapy Association		$250 - $1,000 (in 2004/2005)
American Psychological Association	$1,500	
American Physical Therapy Association	$1,100 (2005) $1,500 (projected for 2006)	

American Speech-Language-Hearing Association	$700 (Typical private practice with hearing aid dispensing capabilities)	$62 (Individual) $167 (Group)
National Association of Social Workers	$500	
American Optometric Association		$500 to $2,000
American Dietetic Association		$118-$144 (hospital facility) $900 (small practice)

Psychological Testing Codes

Richard W. Whitten, MD, informed the HCPAC that there has been confusion by carriers on the appropriate method to code the technician and computer administered psychological testing and neuropsychological testing codes. The HCPAC reaffirmed that supervision as well as interpretation and report, as performed by a qualified health care professional (e.g. a physician or psychologist) are included in the technician and computer administered testing codes (96102, 96103, 96119 and 96120). **The American Psychological Association indicated that they will submit editorial introductory language for the psychological and neuropsychological testing codes to CPT (by March 8, 2006 to be reviewed at the June 8-11, 2006, CPT Editorial Panel meeting) in order to clarify coding issues with these codes.**

AMA RUC HCPAC Staff will work with CPT Staff to indicate proper coding procedures in the CPT Assistant.

Additionally, William Mangold, MD, Contractor Medical Director, expressed willingness to explore payment policy concerns with carriers.

96101 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report (*work RVU=1.86)

96102 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face* (work RVU=0.50)

96103 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report* (work RVU=0.51)

96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (work RVU=1.86)

96118 *Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (work RVU=1.86)

96119 *Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face* (work RVU=0.55)

96120 *Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report* (work RVU=0.51)

AMA/Specialty Society RVS Update Committee
Administrative Subcommittee Report
February 2, 2006

Members Present: Doctors Richard Tuck (Chair), Michael D. Bishop, James Blankenship, Mary Foto, OTR, Peter Hollmann, Barbara Levy, Lawrence Martinelli, Bernard Pfeifer, James Regan, Chester Schmidt, Jr., and Arthur Traugott.

I. Review conflict of interest policy and financial disclosure statement

Doctor Tuck reviewed the current conflict of interest policy to determine if the existing policy was comprehensive in identifying all types of conflict of interests/financial interests. The Administrative Subcommittee identified that family relationships may constitute a conflict or financial interest. **Therefore, the Administrative Subcommittee requests that the conflict of interest policy and statement, as well as the financial disclosure statement include disclosing whether a representative or "family member" has a financial interest.**

In further review of the conflict of interest policy, the Administrative Subcommittee requests that "RUC alternate members" be included in the policy.

The Administrative Subcommittee requests the following changes:

AMA/Specialty Society RVS Update Committee
Conflict of Interest Policy

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

Statement of Compliance with the RUC Conflict of Interest Policy

I understand that I am expected to comply with the Conflict of Interest Policy of the RUC. To my knowledge and belief, I am in compliance with the Conflict of Interest Policy. I have disclosed any financial interests in specific issues considered by RUC, and I have excused myself from deliberation and vote on any issue in which I **or any family member** have a financial interest. I understand that I have a continuing responsibility to comply with the Conflict of Interest Policy, and I will promptly disclose my interests required to be disclosed under the Policy.

Financial Disclosure Statement

For purposes of this Disclosure, "direct financial interest" means:

- A financial ownership interest of 5% or more, or
- A financial ownership interest which contributes materially to your income, or
- A position as proprietor, director, managing partner, key employee or consultant

I certify that any personal **or family member's** direct financial interest, and any affiliations with or involvement in any organization or entity with a direct financial interest, in the relative value recommendations are noted below. Otherwise, my signature indicates that I have no such financial interest, other than in the provision of these services.

Statement of Financial Interest (If more space is needed, submit a signed attachment)

_____
_____
_____
_____

Signature

_____

Date

_____

Print Name

_____

Additionally, the Administrative Subcommittee requests that two procedural steps occur in the RUC process to allow conflicts and financial interests to be made apparent to the RUC.

3. **All RUC members' and alternate members' conflict of interest statements should be disclosed in writing prior to RUC meetings and placed in the agenda book.**
4. **Each presenter verbally confirms any financial interests or lack of financial interests prior to the presentation of each issue/tab.**

II. Re-review of RUC recommendations – new technology/services

At the February 2005 RUC meeting, the Administrative Subcommittee determined that new technology codes should be identified, and approved the following process for formalized review:

The codes that are identified during the RUC review as codes to be re-reviewed in the future will be maintained on a formal list. This list will be placed on a RUC agenda for discussion just prior to the following Five-Year Review. AMA staff would

provide information pertaining to the frequency, expenditures, sites of service, lengths of stay, numbers and types of providers and scientific information for the code and the RUC will then review this information and determine whether the procedure has indeed achieved widespread use of the new technology. If the RUC deems that this procedure has achieved this status, the specialty society will be asked to re-present these codes with information pertaining to the newly achieved wide-spread use of new technology and how this information affects their original RUC recommendation as a part of the Five Year Review. If the RUC deems that wide-spread use of the new technology has not been achieved, the code will go back on the formal list and will be presented at the next Five Year Review.

Recently, the Medicare Payment Advisory Commission (MedPAC) has expressed interest in the identification of new services likely to experience reductions in value. Doctor Rich charged the Administrative Subcommittee with determining:

1. How many years should pass until a new technology code is re-reviewed and if this should be determined on an individual basis or should a set number of years be established.
2. How the RUC should determine whether a particular code reflects new technology.

To address the issue of identifying new evolving technology codes and re-reviewing them, **the Administrative Subcommittee requests:**

- **A check box is added to the RUC survey instrument and summary of recommendation form so that specialty societies/survey respondents may indicate if a new or revised code is considered to be a new technology service.**
- **At each RUC meeting there is a vote on each new and revised code to determine if a code is to be considered a new technology service.**
- **All new technology/services will be placed on the "New Technology List" to be collated and maintained by RUC staff.**
- **The RUC would intend that all services on this list would be reviewed again at some time certain.**
- **The Administrative Subcommittee will discuss a timeline and other processes related to this at the April 2006 meeting.**

III. Confidentiality and Proprietary Rights

Although AMA staff provides the Rules and Procedures document and the RUC Chair, Doctor Rich, reiterates the confidentiality and proprietary rights that all information discussed and materials provided by the AMA or the RUC are proprietary, there continues to be occasional infringements of this rule. Doctor Rich charged the Administrative Subcommittee with developing a penalization reviewing and policy. Discussion ensued as to whether the infraction would be deliberate or inadvertent, with a major or minor consequence.

The Administrative Subcommittee recommends that the RUC follow Section VII. Continued Representation of the Structure and Functions and any enforcement and appropriate penalties on violation of this section are to be determined by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).

Section VII. Continued Representation

A. A representative's continued participation on the RUC and/or any other Committee or Subcommittee is contingent upon the representative complying with the representative complying with the requirements of this Structure and Organization document and the Rules and Procedures adopted by the RUC.

IV. Other Issues

Five-Year Review Subcommittee
Based on recent MedPAC discussions and the RUC's mission to ensure correct valuation of all codes, the Administrative Subcommittee discussed that there should be a process to identify potentially misvalued codes **The Administrative Subcommittee recommends that the RUC develop a new committee to identify potential misvalued codes for the Five-Year Review.**

Definition of Physician Work
In discussing the difficulty to value potentially misvalued codes, a Subcommittee member noted that physician time to perform certain services may decrease due to new evolving technology, benefit to the patient, and ultimately provide cost savings to the overall health care system. A discussion then ensued regarding the RBRVS and the definition of physician work. There was general consensus that the entire issue of how quality, benefit to patients, and overall health care savings could contribute to the physician payment schedule.

The Administrative Subcommittee recommends that the RUC study additional mechanisms for evaluating physician work to include quality measures, efficiency, and value to the patient and health care system, while recognizing that no metric is currently available.

Verification of Accurate Data
Due to various individuals involved in developing specialty society RUC surveys and the summary of recommendation forms submitted to the RUC, verification of the accuracy and integrity of the data to the RUC should occur. **The RUC recommends that RUC Advisors sign a statement to attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of the RUC Advisor's knowledge. RUC Advisors acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative).**

AMA/Specialty Society RVS Update Committee
Pre-Time Workgroup
February 2, 2006

The following members participated in the discussion: Doctors Barbara Levy, (Chair), Norman Cohen, MD, Thomas Felger, MD, Emily Hill, PA-C, Charles Mick, MD, Tye Ouzounian, MD, James Regan, MD, J. Baldwin Smith, MD, Trexler Topping, MD, Maurits Wiersema, MD

Doctor Levy provided the group with background information stating that the RUC has created standards to the typical direct practice expense inputs: clinical labor activities, supplies, and equipment. These standards continue to be applied during each PERC meeting, and assist members in the development of direct inputs for the typical patient encounter. The Pre-Time Workgroup had been charged with creating discussion and making a recommendation to the RUC regarding the standardization of physician pre-service time.

Workgroup members first had a general discussion of when the pre-service period starts, the current CMS definition of pre-time, and what services are necessary for hospital admission that is not separately billable as an E/M service. The Workgroup members believed that in order to establish some standardization they would have to establish some sort of criteria. Benchmarks could be established based on some characteristics of the procedures. In addition, members warned that if a benchmark is developed, as in the PEAC where 090 day global codes were set at 60 minutes of pre-service time, a bar is set, and all codes going forward would likely be set at that time or higher.

The Workgroup acknowledged that the easiest way to create standards would be to create packages based on global periods and the site of service. Members also believed that it may be appropriate to have more than one package per global period depending on the number of services provided in the pre-service time period.

The Workgroup members agreed that the RUC should:

- Establish packages according to the specific details of the services provided
- These details would then make up the services in each package within or among each global period.
- At the next Five Year Review, the RUC may be able to retrospectively slot existing codes into their proper pre-service package with the assistance of the specialty society

In an effort to move this process forward, the workgroup thought that small groups of RUC members, representing surgical and non-surgical specialties, could meet to initially establish the packages for each global period. It was suggested that AMA staff send a letter to all specialties requesting a list of what they view as pre-service physician work activities. These lists would be compiled and discussed by the established groups who would then determine the initial packages.

In addition, the workgroup asked for AMA staff to graph the existing time data in order to identify any groupings within the global periods, and report back to the group at the next meeting.

AMA Specialty Society RVS Update Committee
Practice Expense Subcommittee
Thursday, February 02, 2006

Doctors Topping (Chair), Anthony, Gage, Lichtenfeld, D. Regan, Mick, Moran, and Zwolak met after lunch to discuss the following practice expense Subcommittee items.

Indirect Practice Expense Allocation
The AMA previously had performed the Socioeconomic Monitoring Survey (SMS), which included questions related to physician practice expense, which is currently being used by CMS in their practice expense methodology to develop practice expense relative values. CMS has utilized older 1995 through 1999 SMS data in the practice expense methodology, as the AMA discontinued its survey in the year 2000. Since that time, the RUC and the AMA's Health Policy Group has continued to seek funding and approval for additional surveys, as there is a significant need for more current data.

As stated in the last Physician Payment Schedule Final Rule, CMS has decided not to accept any more supplemental surveys and is seeking a multi-specialty survey with the hope that it is supported by the RUC and other specialties. CMS may representatives informed the Subcommittee that any support or guidance in the design of the survey would be well received. CMS be able to purchase the data from an umbrella group such as the AMA, therefore providing some offset to the cost of such an effort.

Subcommittee members agreed that one of the reasons the SMS survey was discontinued was that the survey included controversial data on physician income and understands that collection of this data may no longer be necessary. Subcommittee members believed that the specialties would be interested in working with the AMA, through the RUC process to design and financially support the survey. It was noted that the survey could be used for not only capturing current practice expense data, but also information on practice liability insurance premiums. The data could also be used to provide information on the overall increase in physician practice expense for use in organized medicine's campaign to replace the SGR. .
The Subcommittee agreed that a multi-specialty survey should be pursued and recommends that **the RUC reaffirm the RUC's November 3, 2004 letter to Doctor Michael Maves that states "We would offer and encourage the AMA to work through the RUC to involve the specialties in both constructing the survey and funding the effort"**

Standardized 090 and 010 Day Global Period Codes and Medical Supplies
CMS representatives again informed the RUC that they intend to apply the standard packages associated with 090 day global codes for the 2007 physician fee schedule. The original CPEP data may have contained some specialty-specific supply items but these items would be replaced with the standard packages. In some cases the supplies may be appropriate but since specialties have not asked for any exceptions to standard, CMS has no way of retaining these items. If CMS changes its practice expense methodology from top down to bottom up and applies the RUC's recommendation for these codes, there may be an adverse affect on the RVUs for some specialty specific codes.

It was explained by RUC members that specialties have known about this for at least three years and have had many opportunities to refine the data. CMS representatives stated that most of the codes where this situation applies are in dermatology and orthopedic surgery

codes. When the standard was created PEAC members mainly focused on the clinical labor inputs and not medical supplies or equipment.
The RUC recommended the following:
AMA staff will provide specialties with a list of CPT codes where there may be specialty-specific supply or equipment items earmarked for deletion when the 090 day standard packages are applied by CMS.

Future Refinement of Direct Practice Expense
This Subcommittee has discussed the future refinement of direct practice expense inputs regarding mechanisms to review services moving into the office setting and for ideas related to the first 5 Year Review of the direct inputs. The Subcommittee continued to discuss these issues in order to establish future RUC policy.

The Subcommittee first questioned whether the statute requiring the review of relative values applied to all relative values; work, practice expense, and practice liability insurance RVUs. If the statute states that all relative values are to be reviewed every 5 years it would be difficult to review all of them simultaneously.
In addition, the Subcommittee questioned what a 5 year review of practice expense RVUs would entail, and what would be reviewed?

AMA staff confirmed via AMA legislative staff that Section 1848 (C) 2(B) Omnibus Budget Reconciliation Act of 1990 requires CMS to comprehensively review all relative values at least every five years and make any needed adjustments. However, there is no explicit outline detailing such a review and there has been no other legislation superseding the 1990 Act.

One suggestion was to start with the oldest practice expense recommendations first and work forward in time, revisiting each code. The RUC could review the direct inputs and adjust them to reflect current medical practice, including any shift in the site of service. The Subcommittee was also concerned that any review of the direct practice expense inputs may reveal changes in physician work. The Subcommittee understood that any review of practice expense would be a huge task, and any process needs to be effective and efficient.

The RUC should conduct a review of the practice expense direct inputs going forward and will outline a process for such review as CMS determines when such review processes should begin.

Equipment Utilization Assumptions
When CMS developed its practice expense methodology it had to make an assumption of the equipment utilization because the data was not collected in the Abt study. CMS initially made an assumption that all equipment is in use 70% of the time the office is open. This greatly overstated the utilization of most equipment, leading to underestimates of equipment costs in the preliminary relative values. In the 1997 NPRM, CMS reduced the equipment utilization rate to 50%. However, an assumption of 50% equipment utilization may underestimate equipment costs for some codes and overestimate equipment costs for other codes

The Subcommittee discussed whether the RUC is interested in studying equipment utilization in an effort to recommend accurate assumptions to CMS. The Subcommittee discussed the possibility of creating a tiered utilization schedule for the various equipment types but realized the task was overwhelming and may be best conducted by CMS using an outside contractor. The

Subcommittee also considered having specialties generate the utilization information and bring it to the RUC for approval, but again they realized this task was huge and there would likely not be the amount of participation by specialties that is required.

The Subcommittee decided not to pursue a resolution to this problem at this time and look forward to CMS's Town Hall meeting on February 15, 2006 when this and other practice expense methodological issues would be discussed. The Subcommittee will continue to monitor CMS's equipment utilization assumptions carefully for new methodological approaches and reexamine them at a later date.

AMA Specialty Society RVS Update Committee
Research Subcommittee
February 2, 2006

Members Present:
Doctors Cohen (Chair), Allen, Derr, Koopman, Hitzeman, Manaker, Przybylski, Siegel, J. B. Smith, L. Smith, P. Smith, S. Smith

I. Comprehensive Review of the RUC Survey Instrument and Summary Form

At recent RUC meetings there have been several discussions held by RUC members that there was a need for a comprehensive review of the RUC Survey Instrument and Summary of Recommendation Form. Several suggestions were made during these discussions regarding what needed to be reviewed. These suggestions and the Research Subcommittee's corresponding actions are as follows:

A) the summary tables in the summary form needed to include a place for the survey time data as well as specialty society recommended time data. The Subcommittee felt this suggestion was valid and would improve the RUC's review of specialty society recommendations. **The Research Subcommittee recommends adding a table to summarize the specialty society recommended data to the summary of recommendation form.**

B) A concern was expressed that the survey instrument allowed multiple E&M procedures to be billed on the same day in the global period, although this was not permissible with CPT coding convention. In addition, there was a suggestion made that prolonged care service codes should be added to the survey instrument to accurately reflect patient care. Doctors Hollmann and Pryzybylski clarified that this discussion centered around an issue from the Five Year Review that the correct method for properly coding a particular code required prolonged care service codes and currently these codes are not a part of the survey instrument. The Research Subcommittee discussed this issue and determined that the prolonged services CPT codes 99354, 99355, 99356 and 99357 should be added to the survey instrument with corresponding explanatory notes to instruct the survey respondent how to appropriately code these procedures. **The Research Subcommittee recommends adding the prolonged services CPT codes to the survey instrument. Doctor Cohen asked Doctors Hollmann, Manaker and Pryzybylski to review the explanatory note after drafted by RUC Staff.**

C) Another concern was expressed about the RUC's current eligible survey respondent policy. The current policy regarding eligible survey respondent is as follows:

The survey should be sent to a sample of physicians from your specialty society. It is also recommended that you survey physicians from a wide array of practice settings: urban vs. rural; solo vs. group practice; and private practice vs. academic setting. Your sample for the mail survey must include a sufficient number of physicians for your society to obtain survey data from 30 respondents. You may choose to survey a larger number of physicians (e.g., 100 or more) to strengthen the rationale for your recommendation and develop estimates that will have greater statistical validity.

The concern expressed is that the existing policy needs to be refined to clearly detail who is able to participate in the survey process without bias. For example, the existing policy does not limit survey participation from various RUC participants.

The Research Subcommittee was reminded by Doctor Rich that RUC members and RUC Alternates are prohibited from participating in their associated specialty society's surveys as part of RUC policy that RUC members do not act as advocates for their specialties. **The Research Subcommittee recommends that this policy be incorporated in the instruction document that is sent with the RUC surveys to specialty society staff to assist specialties in their process of creating their survey sample.**

D) A suggestion was made to add the percent of respondents who have performed the surveyed procedure in the last 12 months to the summary form. This question is currently on the survey instrument but not on the summary form. The question was originally added to assist specialty societies in developing their recommendations.

The Research Subcommittee discussed this issue and determined that not only is the information provided about a survey respondent's performance of the surveyed procedure within the last 12 months not necessary to include on the summary of recommendation form but because the information provided by this question was not instrumental in valuing a new or revised CPT code this question should be removed from the survey instrument. **The Research Subcommittee recommends that the following question be removed from the survey instrument:**

QUESTION 5: How many times have you personally performed these procedures in the past year?
New/Revised Code: _____ Reference Service Code: _____

The RUC discussed this issue and disagreed with the Research Subcommittee's action to delete this question entirely from the RUC survey instrument because the specialty societies find the information from this question to be very useful when calculating their specialty society recommendations. **The RUC recommends maintaining Question 5 on the RUC survey instrument.**

In addition to these items, at the request of the Research Subcommittee Chair, an e-mail was sent to RUC participants to provide their input on items to be added to this agenda item. Eight responses were received. Their comments/suggestions and the Research Subcommittee's corresponding actions are as follows:

- A suggestion from the AGA and the ASGE was that the RUC needs to recognize the discharge day planning activities for 000 day global periods. The current survey and summary of recommendation forms used for 000 day global services do not recognize that physicians who perform endoscopy procedures involving anesthesia/conscious sedation typically perform the same discharge day management activities that are done for 10 and 90 day global services. The Research Subcommittee discussed this issue and determined that this suggestion is a policy issue and needs to be a separate agenda item.

The Research Subcommittee recommends this issue be placed on the April 2006 Research Subcommittee Agenda

- A suggestion was made by multiple respondents to place the following question directly after the vignette within the survey instrument:

  QUESTION 7: Is your typical patient for this procedure similar to the typical patient described on the cover?

  Yes □ No □

  If no, please describe your typical patient for this procedure:

  After some brief discussion the Research Subcommittee agreed that this suggestion would make the survey easier to complete by survey respondents. **The Research Subcommittee recommends placing the aforementioned question directly following the vignette.**

  It was also suggested by respondents to the Research Subcommittee's request that this question should be revised to state, "If no, please do not complete the remainder of the survey." This suggestion was discussed by the Subcommittee and it was decided that even if a survey respondent did not feel the vignette described was typical, the information that he/she could provide the specialty society related to this new or revised service was valuable.

- The existing survey instrument asks the survey respondents for personal information including contact information, specialty, years practicing specialty, geographic information and primary type of practice information. The reason for these questions being on the RUC survey was to allow specialty society staff to be able to contact the survey respondent if they had any further questions regarding their responses; allow them to ensure that a single physician is not completing the same survey more than one time and be certain that their survey sample included responses from various regions and practice types within the country. The Subcommittee discussed this issue and determined that contact information was essential for the specialty society staff to obtain, however, information relating to the survey respondent's address, the fax number and the years of practice within a specialty was superfluous information. **The Research Subcommittee recommends removing from the survey instrument questions regarding, address, fax number and years of practice within a specialty.**

- In the Background for Question 1 of the survey instrument, there are definitions for the various categories of global period. This information was included because survey respondents when reviewing the reference service list, which may include codes of different global periods than the surveyed code, would be able to accurately consider the global period when comparing the surveyed code to the reference code. Several respondents to the Research Subcommittee's request, suggested that for those not familiar with global period descriptors, this information may be confusing and makes the survey instrument less user friendly and recommended that the additional definitions of global periods should be removed from the survey instrument. **The Research Subcommittee agreed with this suggestion and recommends that only the information directly**

pertaining to the global period of the surveyed code should remain on the survey instrument.

- There was a suggestion made by several respondents that the question pertaining to whether someone under the survey respondent's direct supervision typically administers conscious sedation for these procedures should only be placed on surveys where conscious sedation would be inherent when performing the procedure. **The Research Subcommittee before addressing the issue recommended that the term "Conscious Sedation," should be replaced with the current term "Moderate Sedation."** The Research Subcommittee questioned who would determine whether moderate sedation would be inherent in performing the procedure and felt that this question need to be retained to verify through survey responses the inherent or not inherent nature of moderate sedation when performing the surveyed procedure.

- There were several questions that were recommended by respondents to be added to the survey instrument including: whether the survey respondent had completed previous RUC surveys and whether the survey respondent had received instruction from specialty society staff on how to complete the survey. Also, it was suggested that an example should be placed in the survey instrument to demonstrate how to assign physician visits. These suggestions had no support from the Research Subcommittee as the Subcommittee felt that these questions and additions would not assist in valuing the new or revised procedures. **It was also suggested and supported by the Research Subcommittee that on the summary of recommendations, a field should be added to designate whether reference codes utilize RUC or Harvard times as this would assist the RUC in its discussions pertaining to physician times.**

- It was suggested by several respondents that the intensity/complexity measures should be removed. The Research Subcommittee was reminded by RUC Staff that these intensity and complexity measures are an integral part of constructing a rationale to CMS that strongly supports the RUC recommended values. The Research Subcommittee agreed that these intensity/complexity measures were essential to the evaluation process but that the data should be calculated in a more statistically appropriate manner. The Research Subcommittee recommended that RUC Staff obtain guidance from AMA Statisticians on how to best calculate these measures appropriately.

- The American Geriatric Society expressed concern about how effective the survey instruments are for XXX codes and codes where there is no face-to-face time or all face-to-face time. For these procedures, the XXX survey would be utilized which requires specialties to develop generic descriptions of pre-service, intra-service and post-service. Several societies have developed generic descriptions for all of their new or revised XXX global codes. The Research Subcommittee will review these generic description of service periods and further address this issue at the April RUC Meeting.

- There were also various suggestions made by respondents regarding the basic format of the survey instrument and issues concerning the availability of having the survey process completely maintained online. RUC staff will create an entirely new format for the survey instruments based on the discussions held by the Research Subcommittee as well as suggestions and comments received and present this updated survey instrument at the

April RUC Meeting. In addition, RUC staff is in communication with the AMA Surveying Experts to examine the possibilities available to the RUC in conducting its survey process online.

- The American College of Surgeons submitted a letter outlining general discussion of the RUC survey process. The College expressed concern that the specialty survey process be studied to ensure that it remains based on magnitude estimation and not merely a "social survey" collecting the specialties' "wish list." **The Research Subcommittee recommends that as a first step, AMA Staff prepare an analysis of survey medians, specialty recommendations, RUC recommendations and CMS' final implemented relative values to see if the relationship between the survey medians and the final value have changed throughout the process.**

A new draft survey instrument and summary form will be reviewed prior to and finalized at the April 2006 RUC Meeting.

II. Reference Service List Policy

In addition to reviewing the summary of recommendation form and the survey instrument, there was also a request to review the current reference service list policy. The current reference service list policy is as follows:

- *Include a broad range of services and work RVUs for the specialty. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service.*

- *Services on the list should be those which are well understood and commonly provided by physicians in the specialty.*

- *Include codes in the same family as the new/revised code. (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)*

- *If appropriate, codes from the MPC list may be included.*

- *Include RUC validated codes.*

- *Include codes with the same global period as the new/revised code.*

- *Include several high volume codes typically performed by the specialty.*

Doctor Cohen announced that RUC Staff will be providing the Research Subcommittee historical and background documents pertaining to this issue and postponed discussion of this issue to the April RUC Meeting

III. Modifier -51 Exempt Workgroup Update

At the October 05 RUC Meeting, there was a discussion related to the processes in place for determining which codes are exempt from the use of Modifier -51 as listed in Appendix E of the CPT book. The codes listed in Appendix E are not subject to the multiple procedure Modifier -51 reduction, as the values assigned to these codes were already reduced since they are valued to include intra-service work only, with a small amount if any pre- and post-time added. However, the RUC noted that not all of the Modifier -51 exempt codes are valued in such a manner as some of the codes include pre- and post-time, follow-up visits with global periods.

It was recommended to the CPT Editorial Panel that this issue be discussed to consider establishing a process to allow each of the codes listed in Appendix E to be reviewed for appropriateness using a set of criteria to determine whether the value assigned warrants its exemption from the Modifier -51. The CPT Editorial Panel has created a Modifier Workgroup which will review the codes currently given the Modifier -51 exemption to determine its appropriateness of being on the list and to establish criteria that would determine how future codes would be placed on this list i.e., confirming with RUC Staff that no pre- and post-service times are not associated with the proposed codes. The Workgroup has asked for RUC participation. Four members of the Research Subcommittee have volunteered to participate in these meetings: Doctors Derr, Hitzeman, Manaker and Peter Smith. The Workgroup will be meeting during the CPT Meeting February 9-12, 2006. RUC members will be able to participate via conference call. The Research Subcommittee requests a report from the Subcommittee members participating on the call as to the actions items taken by the Workgroup.

AMA/Specialty Society RVS Update Committee
Professional Liability Insurance Workgroup
February 2, 2006

The following members of the Professional Liability Insurance (PLI) Workgroup met on February 2, 2006, to discuss numerous issues related to the CMS methodology to compute PLI relative values. Doctors David Hitzeman (Chair), Michael D. Bishop, Brenda Lewis, Scott Manaker, Guy Orangio, Gregory Przybylski, Sandra Reed, David Regan and Peter Smith.

PLI Premium Collection Efforts

In a letter dated January 11, 2006, CMS has agreed to examine specific malpractice premium data for use in the calculation of the Malpractice Geographic Practice Cost Index (GPCI) available through Doctor Stephen Kamenetzky. Doctor Kamenetzky indicated to AMA staff that he will begin to assemble the data from the Physician Insurers Association of America (PIAA) for the six pilot states (Iowa, Colorado, New York, Florida, Pennsylvania and Texas) that have been chosen. Doctor Kamenetzky indicated that he should be able to obtain this data for CMS in approximately 90 days.

Low Utilization Services

At the April 2005 RUC meeting, the PLI Workgroup reviewed the dominant specialty of 1,844 CPT codes with Medicare utilization in 2003 of fewer than 100 services reported. For approximately 13% (240 CPT codes) of these low utilization services, the recommended specialty to utilize for PLI purposes differs from the dominant specialty. An additional 152 CPT codes have zero Medicare utilization and in this case specialty was recommended. The PLI Workgroup forwarded these recommendations to CMS for consideration in their 2006 rulemaking process. CMS was not able to incorporate such recommendations in the 2006 Final Rule.

The PLI Workgroup recommends that the RUC reaffirm our previous recommendation to CMS that CMS utilize these recommended specialties for low volume codes (ie, fewer than 100 claims per year), rather than rely on claims data.

Discussion of RUC process PLI crosswalks for new codes

The PLI Workgroup reviewed the professional liability insurance information section of the Instructions for Specialty Societies Developing Recommendations (page 10). Doctor Przybylski noted that while CMS methodology utilizes physician work and the specialty risk factor to drive PLI relative values, however, the work RVU may not always be the best surrogate for a crosswalk. Other measures such as intra-service work may be more appropriate. **The PLI Workgroup recommends that the instructions be refined to include other measures.**

> Professional Liability Insurance Information
> New and revised CPT codes are temporarily assigned a professional liability insurance (PLI) relative value based on CMS staff analysis of an appropriate crosswalk. The crosswalk should represent a code with a similar work RVU **or other appropriate measure** and be performed by the same specialty. The RUC has agreed that specialty input into this crosswalk is important and is providing that opportunity by including a section on the Summary of Recommendation Form to specifically collect this information. Please complete this section of the Summary form with your specialty RVS committee.

The PLI Workgroup also reviewed the professional liability insurance information section of the summary of recommendation form (page 5). The PLI Workgroup recommends that further directions be provided on the determination of surgical versus non-surgical risk factors so that specialties understand the distinction as defined by CMS.

Other Issues

A PLI Workgroup member suggested, and the Workgroup agreed that CMS request physicians to provide PLI premium information on an annual basis. However, the full RUC did not accept this recommendation.

The PLI Workgroup discussed the probability of a multi-specialty endeavor to gather PLI premium information. Specifically, with the implementation of National Provider Identifiers (NPIs) such collection efforts may be possible directly through CMS.

The Workgroup continued to discuss that it would be helpful for CMS to identify the key elements CMS would require to use in their PLI methodology.

The PLI Workgroup also discussed the possibility of gathering PLI information as part of the PE multi-specialty survey process if it occurs.

AMA/Specialty Society RVS Update Committee
E/M Workgroup Report
January 16, 2006

The following members of the Evaluation and Management (E/M) Workgroup participated in four conference calls (October 19, November 28, December 14, and January 5) to consider interim and postponed actions related to E/M services in the third, Five-Year Review of the RBRVS:

Norman Cohen, MD, Chairman
John Derr, MD
William Gee, MD
David Hitzeman, DO
George Kwass, MD
Doug Leahy, MD
Charles Mabry, MD
Greg Przybylski, MD
J. Baldwin Smith, MD
Maurits Wiersema, MD

This report will first summarize the discussions at each conference call and then provide a number of recommendations for full RUC consideration. At the February 2-5, 2006 meeting, the RUC must finalize actions on the following E/M codes:

99213, 99214, 99215 - Postponed until February 2006
99222 - 2.56 (interim)
99223 - 3.78 (interim)
99232 - 1.30 (interim)
99233 - 2.00 (interim)
99291 - 4.29 (interim)
99292 - 2.15 (interim)

October 19, 2005

The E/M Workgroup convened a call to discuss next steps in establishing RUC recommendations for CPT codes 99213, 99214, and 99215 and the process to review the interim recommendations for 99222, 99223, 99322, 99323, 99291, and 99292. Sherry Smith clarified that this E/M Workgroup is charged with the short-term process of developing recommendations for the RUC to review in February 2006. Doctor Rich has proposed development of a long-term review workgroup to study E/M and its placement within the RBRVS that would begin at the conclusion at this Five-Year Review process.

The Workgroup quickly came to consensus that a re-survey of these services would not generate any additional beneficial information to assist the RUC in completing its review of E/M services. However, the Workgroup requested that AMA staff collect the existing survey data from both the medical and surgical specialty societies and analyze this information. AMA staff were to specifically weigh this survey data to the Medicare 2004 utilization data by specialty. This

is consistent to the collation of data from the 1995 Five-Year Review of E/M. Additional regression analysis regarding potential increments between coding content and other elements could also be explored by AMA staff, if the Workgroup finds this necessary.

Workgroup members discussed other approaches to establish the E/M work values, independent of the survey data. For example, one Workgroup member proposed utilizing IWPUT to fill in the gaps for the remaining nine codes. Another Workgroup member proposed utilization of the relative values accepted by the RUC in October for the majority of the E/M codes to determine appropriate increments for the remaining codes to be resolved. A continued comparison of the E/M codes to other imaging and minor procedure codes will also be explored.

November 28, 2005

The primary focus of the second E/M Workgroup conference call was to receive and discuss new data analysis of the raw survey data collected by both the medical specialty societies and the surgical specialty societies. AMA staff compiled several tables (attached) with the weighted survey data utilizing individual survey responses. These tables are presented with data from all surveys (medical and surgical); those where the respondent indicated that the vignette was typical; and medical respondents only. AMA staff provided the following notes regarding this analysis:

Notes Regarding Specialty Representation in the Survey Data:

Although there appears to be a larger number of family medicine respondents than presented in the earlier data, the data is consistent. The August E/M Workgroup had initially requested that the data be supplied by "specialty society." The vast majority of the American Osteopathic Association's respondents indicated family medicine as their specialty, therefore the family medicine number of respondents is more representative than previously indicated by the differentiation by specialty society.

Also, please note that the original medical specialty data included incorrect numbers related to the number of respondents. For example, there is a sharp decline in the number of endocrinologists. This resulted from a misunderstanding that an individual should be counted as a respondent if they initiate the on-line survey, even if they did complete the major portions of the survey. AMA staff removed all survey responses where the individual respondent did not complete the work relative value recommendation question for any of the codes in the family.

Weighting Methodology

The ratio of the percentage of Medicare frequency to the percentage of respondents was used to determine the work relative value weight. The weight for pre, intra, and post-service time was calculated utilizing the percent of respondents for those time elements separately. Note also that separate weights were calculated for the 'typical vignette only' and 'medical specialty only' and 'all specialty' results. The weighted percentiles were calculated using SAS version 8.2, using the UNIVARIATE procedure with a WEIGHT statement. To get the weighted percentile 'p', we

first ranked the (non-missing) responses in ascending order and calculate the sum of the weights, W. The percentile 'p' response is the first observation where the cumulative weight exceeds pW. The methodology is described in the SAS 8 Procedures Guide, UNIVARIATE procedure, under the section titled "weighted quartiles".

New Medical Specialty Society Request and Workgroup Discussion

On this call, the medical specialty societies indicated that they had reviewed the new weighted survey data and wished the Workgroup to consider the following relative value recommendations:

99213 1.00 (August WG - 0.80)
99214 1.50 (August WG - 1.30)
99215 2.00 (August WG - 2.00)
99222 2.56 (August WG - 2.56/RUC - 2.56 (interim))
99223 3.78 (August WG - 3.78/RUC - 3.78 (interim))
99232 1.50 (August WG - 1.30/RUC - 1.30 (interim))
99233 2.00 (August WG - 2.00/RUC - 2.00 (interim))

The Workgroup then discussed three codes (99222, 99223, and 99233) on the conference call. Although, the Workgroup did come to a majority agreement on 99223 and 99233 (vote 6-4), a decision was made to convene a new call in December after the surgeons prepared a written document outlining their continued concerns with the August E/M Workgroup recommendations.

December 14, 2005

The Workgroup initiated the call by discussing a request from the surgeons to utilize the weighted survey time data, rather than the data first presented to the August E/M Workgroup. A clarification in process was made that those codes in which the work relative values and physician time data had been fully approved by the RUC in October would require a request for reconsideration prior to any discussion in regards to modifications to the physician time data. However, the Workgroup can proceed with new recommendations related to physician time for the nine codes that are interim or postponed. The Workgroup then agreed (9 agreed,1 abstained) that the weighted survey time data for those respondents who indicated that the vignette was typical was the most representative time data and agreed that this time data should be recommended for each of the nine codes in question. The weighted survey data is attached to this report. To summarize, the physician time data for the nine codes under review by the Workgroup will be submitted to the RUC as follows:

Code:	Pre/Intra/Post
99213	5/15/5
99214	5/25/10
99215	7/40/15
99222	10/40/15

99223	15/55/20
99232	10/20/10
99233	10/30/15
99291	15/40/15
99292	0/30/0

The Workgroup noted that the representatives of critical care should comment on the time for 99291/99292. However, the weighted typical survey time is the same as the intra-service time data already presented by the specialty.

The Workgroup then re-visited its discussion from the November 28 conference call related to codes 99222 and 99233. The Workgroup was able to come to 100% agreement that the work relative values for two hospital codes should be valued at the August Workgroup and October RUC Interim recommendations, as follows:

99222	2.56 (Original August E/M Workgroup Recommendation - Interim RUC Rec.)
99233	2.00 (Original August E/M Workgroup Recommendation - Interim RUC Rec.)

The Workgroup also agreed that work relative value for 99223 should be valued at the August Workgroup and October RUC Interim recommendations, as follows:

99223	3.78 (Original August E/M Workgroup Recommendation - Interim RUC Rec.)

However, three Workgroup members (vote 7-3) offered a minority report for 99223 (see page 5 of the attached December 13, 2005 memo from the American College of Surgeons for rationale).

E/M in Surgical Global Period

During this conference call, Workgroup members raised the issue of including all E/M increases in the surgical global period. Several Workgroup members argued that it would be appropriate to crosswalk the E/M relative values to the E/M codes included in the surgical global period at 100% of their value. The Workgroup agreed to table this discussion until their next conference call and to review it as the first order of business.

A number of questions were raised during the discussion regarding the previous Five-Year Review and the incorporation of the E/M increases in the global period. Attached is the report generated by Dann Dunn for your review on this topic.

In addition, others raised questions about the global period policy in general. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89, PL 101-239), which established the RBRVS, required CMS to establish a uniform global surgical policy. It appears that any action related to repealing global surgical package policy would require legislative action. If certain specialties are interested in this issue, the best forum to discuss this would be in policy development through the AMA House of Delegates as the Council of Medical Services will be researching and preparing a report on global surgical policies for the Interim 2006 House of Delegates meeting. This report will study the coding rules, payment policies, legal and ethical issues related to reimbursement of

physicians for services rendered in the postoperative global period. The House of Delegates recognized that the contributions of specialty societies would be valuable to the study.

January 5, 2006

In preparation for this final monthly conference call of the E/M Workgroup, a request was made that the medical specialties articulate their recommendations on the remaining codes to be resolved (99213, 99214, 99215, 99232, 99291, and 99291). The medical specialties submitted a memo on January 5th to the E/M Workgroup, with the following recommendations for these six unresolved codes:

99213	1.00
99214	1.50
99215	2.00
99232	1.50
99291	5.00
99292	2.50

E/M in Surgical Global Period

As indicated at the conclusion of the December 14 conference call, the call initiated with a discussion related to the E/M valuation within the surgical global period. Doctor Leahy indicated that the codes with surgical global periods should be increased to incorporate increases in the E/M services as work should be considered equivalent across all specialties and the discounts applied in the first Five-Year Review are not appropriate [see attached summary for codes that are currently discounted within the global]. He also indicated that the MEC agrees with the RUC's March 1997 recommendation to CMS that "the most recent and accurate data should be used to determine the number and level of hospital and office visits in global service work." However, Doctor Leahy indicated that they have a few of concerns that they would request to be addressed. For example, the assumptions regarding the number and level of E/M codes in the global period largely goes untested. Individuals within the MEC have questioned whether these post-operative visits would sustain an audit process if the same 1995/1997 documentation guidelines for stand alone E/M codes were applied to the visits in the global period. These statements engendered a great deal of discussion amongst the Workgroup members.

AMA staff informed the Workgroup that only 32 codes have a 99215 bundled into the service and only 311 codes have a 99214 bundled into the service. The RUC is responsible for ensuring that the number and level of visits in the surgical global period is appropriate. The RUC has made many adjustments to the number and/or level of E/M visits in the global period throughout its review process.

Other discussion focused on whether the post-service work of documentation differed between the stand alone E/M services and the E/M services in the surgical global periods. Some Workgroup members indicated that there is not any difference in the way they handle charting for patients seen post-operatively versus those seen for a service unrelated a surgical procedure. Others on the call indicated that there is a different level of documentation in general between

those services performed independently of procedures and those that are a component of the global surgical period.

The Workgroup agreed (8 agree and 1 abstained) that a crosswalk of 100% of the E/M increases should be bundled into the codes with surgical global periods of 010 and 090 days, with the provision that the 1995/1997 documentation requirements, whether element based or time based, are the same as stand alone E/M. The Workgroup acknowledged that that the RUC is not the appropriate forum to discuss enforcement of documentation requirements. One Workgroup member abstained as he did not feel that the RUC would be the appropriate mechanism to enforce documentation in E/M services performed in the postoperative period, but CMS would be responsible for any such implementation. Another Workgroup member also voiced concern that payors would use an audit process to reduce payment if the number of visits were less than the number captured as "typical" in the global surgical period.

Valuation of 99215

The Workgroup understands from a review of the September 29-October 2, 2005 meeting that 2/3 of the RUC would support a relative value recommendation at or above the August E/M Workgroup recommendation of 2.00. However, at that time several RUC members refused to consider a value below 2.15. The presenting medical specialties have indicated since the November 28, 2005 conference call that they would accept the August E/M Workgroup recommendation of 2.00. The Workgroup agreed that work relative value for 99215 should be valued at the August Workgroup recommendation:

99215 2.00 (Original August E/M Workgroup Recommendation)

However, two Workgroup members (vote 7-2) offered a minority report for 99215 (see page 4 of the attached December 13, 2005 memo from the American College of Surgeons for rationale.)

Valuation of 99213

The E/M Workgroup then attempted to come to consensus on 99213. The Workgroup understands from a review of the September 29-October 2, 2005 meeting that 2/3 of the RUC would support a relative value recommendation at or above the August E/M Workgroup recommendation of 0.80. The Workgroup then reviewed the January 5 memo from the MEC related to their rationale for 99213. In this memo, the MEC recommends a work relative value of 1.00 for 99213. Some Workgroup members offered criticism of comparison to certain reference services discussed in the memo, such as insertion of IUD and nasal endoscopy, as they had not been recently reviewed by the RUC. Others found support in a value between 0.88 - 0.92 for 99213 in the following rationale:

> *As the RUC recommendations for the 1995 Five-Year Review were 0.80 for 99213 and 0.79 for 99202 due to the more complex decision making and higher intensity of 99213, the current RUC recommendation of 0.88 for 99202 should be less than the work relative value for 99213.*

Doctor Mabry argued that the RUC's previous linkage of 99202 and 99213 may indicate that the RUC's recommendation on 99202 in October was too high. Doctor Cohen reminded the Workgroup members that all recommendations submitted to CMS in October are considered final and a formal request for reconsideration would be the appropriate process to re-review any of the previous RUC actions.

To help determine where the Workgroup members were able to vote on at this particular time, Doctor Cohen requested that each of the nine members on the call express their recommendation for 99213. One Workgroup member recommended that 99213 be maintained at 0.67. Two individuals stated that they support the Workgroup recommendation of 0.80. Four individuals stated that they would support a recommendation ranging from 0.88 - 0.92. Two individuals would recommend a work relative value of 1.00. Given the wide range of opinion regarding the valuation of 99213, the Workgroup recommends that the RUC consider the value of 99213 as a committee of the whole.

Valuation of 99214

The Workgroup acknowledges that neither the RUC, nor this Workgroup, have discussed the valuation of 99214. However, the Workgroup believes that the RUC must first resolve 99213. The August E/M Workgroup recommendation for 99214 was 1.30. The MEC is recommended a work relative value of 1.50.

Valuation of 99232

The August E/M Workgroup also recommended a work relative value of 1.30 for 99232 and the RUC approved this as an interim recommendation in October. However, the MEC is recommending a work relative of 1.50. The Workgroup believes that it is appropriate that the RUC, as a committee of the whole, resolve this valuation.

Critical Care

The RUC approved an interim work relative value of 4.29 for 99291 and 2.15 for 99292 to avoid creation of rank order anomalies with other higher level hospital codes. The presenting specialty societies had requested that these recommendations remain interim until all of the other E/M services were resolved. As three codes remain unresolved at this time, the presenting specialties for critical care has requested that they have the opportunity to present at the full RUC meeting, upon completion of the other E/M services. At this point, the specialty societies are requesting that the RUC consider 5.00 for 99291 and 2.50 for 99292.

E/M Workgroup Recommendations for RUC Action

#1 - The E/M Workgroup recommends that the weighted survey time data from those respondents who indicated that the vignette was typical should be utilized as the physician time recommendations for those codes in that E/M Workgroup was charged to review, as follows:

Code:	Pre	Intra	Post	Total
99213	5	15	5	25
99214	5	25	10	40
99215	7	40	15	62
99222	10	40	15	65
99223	15	55	20	90
99232	10	20	10	40
99233	10	30	15	55
99291	15	40	15	70
99292	0	30	0	30

The RUC concluded that the "all" survey respondent median time data should be utilized on an interim basis for all E/M codes under review. The RUC will continue to study the E/M physician time data as it conducts a long-term review of E/M valuation.

#2 - The E/M Workgroup recommends that the RUC approve a work relative value recommendation of 2.56 be approved for 99222. This is the original August E/M Workgroup recommendation and the October Interim RUC recommendation.

#3 - The E/M Workgroup recommends that the RUC approve a work relative value recommendation of 3.78 be approved for 99223. This is the original August E/M Workgroup recommendation and the October Interim RUC recommendation.

#4 - The E/M Workgroup recommends that the RUC approve a work relative value recommendation of 2.00 be approved for 99233. This is the original August E/M Workgroup recommendation and the October Interim RUC recommendation.

#5 - The E/M Workgroup recommends that the RUC approve a work relative value recommendation of 2.00 be approved for 99215. This is the original August E/M Workgroup recommendation.

The RUC approved the E/M Workgroup recommendations for 99222, 99223, 99233, and 99215.

#6 - The Workgroup recommends that a crosswalk of 100% of the E/M increases should be bundled into the codes with surgical global periods of 010 and 090 days, with the provision that the 1995/1997 documentation requirements, whether element based or time based, are the same as stand alone E/M.

The RUC agreed that E/M work is equivalent and a crosswalk of 100% of the E/M valuation should be bundled into the codes with global periods of 010 and 090 days, with appropriate documentation

The full RUC will need to review, discuss, and determine the relative value recommendations for CPT codes 99213, 99214, 99232, 99291, and 99292.

The RUC completed its review of CPT codes 99213, 99214, 99232, 99291, and 99292 and finalized recommendations for each of these codes.

Attachments

- January 16, 2006 minority opinion from Doctors Gage/Mabry
- Spreadsheet summarizing relative values and physician time data
- RUC Recommendations submitted to CMS on October 31, 2005
- Minutes from September 29-October 2, 2005 RUC Meeting
- Weighted survey data prepared by AMA staff
- Suggested valuation approach proposed by David Hitzeman, DO
- January 5, 2006 Memo from Medical Executive Committee
- 1995 RUC E/M Recommendations
- December 13, 2005 Minority Response Memo
- Dan Dunn analysis of E/M in the global period
- One page summary form of current E/M valuation and time in the global period

AMA
AMERICAN
MEDICAL
ASSOCIATION

February 27, 2006

Terry Kay
Centers for Medicare and Medicaid Services
7500 Security Blvd, C4-01-15
Baltimore, MD 21244

Dear Mr. Kay:

The American Medical Association/Specialty Society RVS Update Committee (RUC) had a meeting February 2-5, 2006. At this meeting the RUC determined that it was important to reinforce our previous recommendation that CMS use the RUC's recommended dominant specialty for low volume codes rather than rely on claims data in your PLI methodology.

After an exhaustive review of 1,844 codes with utilization less than 100 Medicare claims per year, the RUC forwarded a suggested dominant specialty for each of these low volume codes to CMS and suggested the use of this list as a substitution for claims data. CMS has indicated that in most cases, the dominant specialty suggested by the RUC is reflected as the specialty with the highest utilization in the most recent dataset. This may be true, as these errors in claims will impact low volume codes differently each year. However, the RUC strongly urges that CMS should not rely on claims data to determine the appropriate PLI specialty risk factor for these very low volume codes, but instead use the list as developed by the RUC.

The selection of the appropriate specialty may have a significant effect, particularly for those specialties with high PLI premiums. The following is an example of this impact:

	Specialty in Medicare Utilization	Work	PE	PLI
61705	Neurosurgery	36.15	19.31	8.84
61708	Diagnostic Radiology	35.25	15.19	2.50

In this case, staff predicted that neurosurgery should be the specialty for this entire family of services, 61705, 61708, and 61710. The only way to safeguard these low volume services from this type of error caused by claims data is to assign the specialty for these cods and avoid any year-to-year fluctuations.

We submit the attached list of recommended specialties for low volume codes again and urge its use for establishing PLI relative values for 2007.

Sincerely,

William L. Rich, III, MD, FACS

cc: Rick Ensor
Stephanie Monroe
Carolyn Mullen
RUC participants

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
0008T	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with suturing of the esophagogastric junction	GASTROENTEROLOGY	10
0010T	Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response	PATHOLOGY	22
0017T	Destruction of macular drusen, photocoagulation	OPHTHALMOLOGY	18
0023T	Infectious agent drug susceptibility phenotype prediction using genotypic comparison to known genotypic/phenotypic database, HIV 1	PATHOLOGY	22
0024T	Non-surgical septal reduction therapy (eg, alcohol ablation), for hypertrophic obstructive cardiomyopathy, with coronary arteriograms, with or without temporary pacemaker	CARDIOLOGY	06
0027T	Endoscopic lysis of epidural adhesions with direct visualization using mechanical means (eg, spinal endoscopic catheter system) or solution injection (eg, normal saline) including radiologic localization and epidurography	ANESTHESIOLOGY	05
0028T	Dual energy x-ray absorptiometry (DEXA) body composition study, one or more sites	DIAGNOSTIC RADIOLOGY	30
0031T	Speculoscopy;	OB-GYN	16
0033T	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection; involving coverage of left subclavian artery origin, initial endoprosthesis	VASCULAR SURGERY	77
0034T	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection; not involving coverage of left subclavian artery origin, initial endoprosthesis	VASCULAR SURGERY	77
0035T	Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection; initial extension	VASCULAR SURGERY	77
0036T	Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection; each additional extension (List separately in addition to code for primary procedure)	VASCULAR SURGERY	77
0038T	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection involving coverage of left subclavian artery origin, initial endoprosthesis, radiological supervision and interpretation	VASCULAR SURGERY	77
0039T	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection not involving coverage of left subclavian artery origin, initial endoprosthesis, radiological supervision and interpretation	VASCULAR SURGERY	77

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
0040T	Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection, each extension, radiological supervision and interpretation	VASCULAR SURGERY	77
0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	DIAGNOSTIC RADIOLOGY	30
0044T	Whole body integumentary photography, at request of a physician, for monitoring of high-risk patients; with dysplastic nevus syndrome or familial melanoma	DERMATOLOGY	07
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm (List separately in addition to code for primary procedure)	PLASTIC AND RECONSTUCTIVE SURGERY	24
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	PLASTIC AND RECONSTUCTIVE SURGERY	24
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	PLASTIC AND RECONSTUCTIVE SURGERY	24
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	PLASTIC AND RECONSTUCTIVE SURGERY	24
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	PLASTIC AND RECONSTUCTIVE SURGERY	24
11975	Insertion, implantable contraceptive capsules	OB-GYN	16
11976	Removal, implantable contraceptive capsules	OB-GYN	16
11977	Removal with reinsertion, implantable contraceptive capsules	OB-GYN	16
12017	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	EMERGENCY MEDICINE	93
12018	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	EMERGENCY MEDICINE	93
12047	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm	GENERAL SURGERY	02
12056	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	PLASTIC AND RECONSTUCTIVE SURGERY	24
12057	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	PLASTIC AND RECONSTUCTIVE SURGERY	24
15775	Punch graft for hair transplant; 1 to 15 punch grafts	PLASTIC AND RECONSTUCTIVE SURGERY	24

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
15776	Punch graft for hair transplant; more than 15 punch grafts	PLASTIC AND RECONSTUCTIVE SURGERY	24
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	DERMATOLOGY	07
15782	Dermabrasion; regional, other than face	DERMATOLOGY	07
15783	Dermabrasion; superficial, any site, (eg, tattoo removal)	DERMATOLOGY	07
15792	Chemical peel, nonfacial; epidermal	DERMATOLOGY	07
15793	Chemical peel, nonfacial; dermal	DERMATOLOGY	07
15810	Salabrasion; 20 sq cm or less	PLASTIC AND RECONSTUCTIVE SURGERY	24
15811	Salabrasion; over 20 sq cm	PLASTIC AND RECONSTUCTIVE SURGERY	24
15819	Cervicoplasty	PLASTIC AND RECONSTUCTIVE SURGERY	24
15824	Rhytidectomy; forehead	PLASTIC AND RECONSTUCTIVE SURGERY	24
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	PLASTIC AND RECONSTUCTIVE SURGERY	24
15826	Rhytidectomy; glabellar frown lines	PLASTIC AND RECONSTUCTIVE SURGERY	24
15828	Rhytidectomy; cheek, chin, and neck	PLASTIC AND RECONSTUCTIVE SURGERY	24
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	PLASTIC AND RECONSTUCTIVE SURGERY	24
15832	Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh	PLASTIC AND RECONSTUCTIVE SURGERY	24
15833	Excision, excessive skin and subcutaneous tissue (including lipectomy); leg	PLASTIC AND RECONSTUCTIVE SURGERY	24
15834	Excision, excessive skin and subcutaneous tissue (including lipectomy); hip	PLASTIC AND RECONSTUCTIVE SURGERY	24
15835	Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock	PLASTIC AND RECONSTUCTIVE SURGERY	24
15836	Excision, excessive skin and subcutaneous tissue (including lipectomy); arm	PLASTIC AND RECONSTUCTIVE SURGERY	24
15837	Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand	PLASTIC AND RECONSTUCTIVE SURGERY	24

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
15838	Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad	PLASTIC AND RECONSTUCTIVE SURGERY	24
15841	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)	PLASTIC AND RECONSTUCTIVE SURGERY	24
15842	Graft for facial nerve paralysis; free muscle flap by microsurgical technique	PLASTIC AND RECONSTUCTIVE SURGERY	24
15876	Suction assisted lipectomy; head and neck	PLASTIC AND RECONSTUCTIVE SURGERY	24
15877	Suction assisted lipectomy; trunk	PLASTIC AND RECONSTUCTIVE SURGERY	24
15878	Suction assisted lipectomy; upper extremity	PLASTIC AND RECONSTUCTIVE SURGERY	24
15879	Suction assisted lipectomy; lower extremity	PLASTIC AND RECONSTUCTIVE SURGERY	24
15922	Excision, coccygeal pressure ulcer, with coccygectomy; with flap closure	PLASTIC AND RECONSTUCTIVE SURGERY	24
15953	Excision, trochanteric pressure ulcer, with skin flap closure; with ostectomy	PLASTIC AND RECONSTUCTIVE SURGERY	24
17380	Electrolysis epilation, each 1/2 hour	DERMATOLOGY	07
19220	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	GENERAL SURGERY	02
19272	Excision of chest wall tumor involving ribs, with plastic reconstruction; with mediastinal lymphadenectomy	THORACIC SURGERY	33
19324	Mammaplasty, augmentation; without prosthetic implant	PLASTIC AND RECONSTUCTIVE SURGERY	24
19355	Correction of inverted nipples	PLASTIC AND RECONSTUCTIVE SURGERY	24
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	PLASTIC AND RECONSTUCTIVE SURGERY	24
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	PLASTIC AND RECONSTUCTIVE SURGERY	24
19396	Preparation of moulage for custom breast implant	PLASTIC AND RECONSTUCTIVE SURGERY	24
20101	Exploration of penetrating wound (separate procedure); chest	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
20150	Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision	ORTHOPEDIC SURGERY	20
20662	Application of halo, including removal; pelvic	ORTHOPEDIC SURGERY	20
20663	Application of halo, including removal; femoral	ORTHOPEDIC SURGERY	20
20664	Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta), requiring general anesthesia	NEUROSURGERY	14
20802	Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation	ORTHOPEDIC SURGERY	20
20805	Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputation	ORTHOPEDIC SURGERY	20
20808	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation	ORTHOPEDIC SURGERY	20
20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	ORTHOPEDIC SURGERY	20
20822	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion), complete amputation	ORTHOPEDIC SURGERY	20
20824	Replantation, thumb (includes carpometacarpal joint to MP joint), complete amputation	ORTHOPEDIC SURGERY	20
20827	Replantation, thumb (includes distal tip to MP joint), complete amputation	ORTHOPEDIC SURGERY	20
20838	Replantation, foot, complete amputation	ORTHOPEDIC SURGERY	20
20910	Cartilage graft; costochondral	ORTHOPEDIC SURGERY	20
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision	ORTHOPEDIC SURGERY	20
20956	Bone graft with microvascular anastomosis; iliac crest	ORTHOPEDIC SURGERY	20
20957	Bone graft with microvascular anastomosis; metatarsal	ORTHOPEDIC SURGERY	20
20962	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal	ORTHOPEDIC SURGERY	20
20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	PLASTIC AND RECONSTUCTIVE SURGERY	24
20972	Free osteocutaneous flap with microvascular anastomosis; metatarsal	ORTHOPEDIC SURGERY	20
20973	Free osteocutaneous flap with microvascular anastomosis; great toe with web space	ORTHOPEDIC SURGERY	20
21010	Arthrotomy, temporomandibular joint	MAXILLOFACIAL SURGERY	85

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
21047	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))	OTOLARYNGOLOGY	04
21049	Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))	OTOLARYNGOLOGY	04
21050	Condylectomy, temporomandibular joint (separate procedure)	MAXILLOFACIAL SURGERY	85
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	MAXILLOFACIAL SURGERY	85
21070	Coronoidectomy (separate procedure)	MAXILLOFACIAL SURGERY	85
21077	Impression and custom preparation; orbital prosthesis	ORAL SURGERY	19
21082	Impression and custom preparation; palatal augmentation prosthesis	ORAL SURGERY	19
21083	Impression and custom preparation; palatal lift prosthesis	ORAL SURGERY	19
21084	Impression and custom preparation; speech aid prosthesis	ORAL SURGERY	19
21086	Impression and custom preparation; auricular prosthesis	ORAL SURGERY	19
21088	Impression and custom preparation; facial prosthesis	ORAL SURGERY	19
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	ORAL SURGERY	19
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21121	Genioplasty; sliding osteotomy, single piece	ORAL SURGERY	19
21122	Genioplasty; sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21125	Augmentation, mandibular body or angle; prosthetic material	ORAL SURGERY	19
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	ORAL SURGERY	19
21137	Reduction forehead; contouring only	PLASTIC AND RECONSTUCTIVE SURGERY	24
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	PLASTIC AND RECONSTUCTIVE SURGERY	24

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	MAXILLOFACIAL SURGERY	85
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	MAXILLOFACIAL SURGERY	85
21143	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft	MAXILLOFACIAL SURGERY	85
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	MAXILLOFACIAL SURGERY	85
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	MAXILLOFACIAL SURGERY	85
21147	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	MAXILLOFACIAL SURGERY	85
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	OTOLARYNGOLOGY	04
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	OTOLARYNGOLOGY	04
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	OTOLARYNGOLOGY	04
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	OTOLARYNGOLOGY	04
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	OTOLARYNGOLOGY	04
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	OTOLARYNGOLOGY	04
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	NEUROSURGERY	14
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	PLASTIC AND RECONSTUCTIVE SURGERY	24

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	PLASTIC AND RECONSTUCTIVE SURGERY	24
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	PLASTIC AND RECONSTUCTIVE SURGERY	24
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm	PLASTIC AND RECONSTUCTIVE SURGERY	24
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm	PLASTIC AND RECONSTUCTIVE SURGERY	24
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	OTOLARYNGOLOGY	04
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	ORAL SURGERY	19
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	OTOLARYNGOLOGY	04
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	OTOLARYNGOLOGY	04
21199	Osteotomy, mandible, segmental; with genioglossus advancement	OTOLARYNGOLOGY	04
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	OTOLARYNGOLOGY	04
21209	Osteoplasty, facial bones; reduction	MAXILLOFACIAL SURGERY	85
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21242	Arthroplasty, temporomandibular joint, with allograft	MAXILLOFACIAL SURGERY	85
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	MAXILLOFACIAL SURGERY	85
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	OTOLARYNGOLOGY	04
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	OTOLARYNGOLOGY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	ORAL SURGERY	19
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	ORAL SURGERY	19
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	OTOLARYNGOLOGY	04
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	PLASTIC AND RECONSTUCTIVE SURGERY	24
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	PLASTIC AND RECONSTUCTIVE SURGERY	24
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement	OPHTHALMOLOGY	18
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	PLASTIC AND RECONSTUCTIVE SURGERY	24
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	PLASTIC AND RECONSTUCTIVE SURGERY	24
21270	Malar augmentation, prosthetic material	PLASTIC AND RECONSTUCTIVE SURGERY	24
21275	Secondary revision of orbitocraniofacial reconstruction	PLASTIC AND RECONSTUCTIVE SURGERY	24
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach	OTOLARYNGOLOGY	04
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach	OTOLARYNGOLOGY	04
21300	Closed treatment of skull fracture without operation	NEUROSURGERY	14
21338	Open treatment of nasoethmoid fracture; without external fixation	OTOLARYNGOLOGY	04
21339	Open treatment of nasoethmoid fracture; with external fixation	OTOLARYNGOLOGY	04
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	OTOLARYNGOLOGY	04
21343	Open treatment of depressed frontal sinus fracture	OTOLARYNGOLOGY	04
21344	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	OTOLARYNGOLOGY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	OTOLARYNGOLOGY	04
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	OTOLARYNGOLOGY	04
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	OTOLARYNGOLOGY	04
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)	OTOLARYNGOLOGY	04
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	OTOLARYNGOLOGY	04
21366	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21386	Open treatment of orbital floor blowout fracture; periorbital approach	PLASTIC AND RECONSTUCTIVE SURGERY	24
21387	Open treatment of orbital floor blowout fracture; combined approach	PLASTIC AND RECONSTUCTIVE SURGERY	24
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	PLASTIC AND RECONSTUCTIVE SURGERY	24
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	PLASTIC AND RECONSTUCTIVE SURGERY	24
21406	Open treatment of fracture of orbit, except blowout; without implant	PLASTIC AND RECONSTUCTIVE SURGERY	24
21408	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	ORAL SURGERY	19
21423	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches	PLASTIC AND RECONSTUCTIVE SURGERY	24
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	ORAL SURGERY	19

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	PLASTIC AND RECONSTUCTIVE SURGERY	24
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	PLASTIC AND RECONSTUCTIVE SURGERY	24
21435	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	PLASTIC AND RECONSTUCTIVE SURGERY	24
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	ORAL SURGERY	19
21451	Closed treatment of mandibular fracture; with manipulation	ORAL SURGERY	19
21452	Percutaneous treatment of mandibular fracture, with external fixation	MAXILLOFACIAL SURGERY	85
21454	Open treatment of mandibular fracture with external fixation	ORAL SURGERY	19
21465	Open treatment of mandibular condylar fracture	ORAL SURGERY	19
21490	Open treatment of temporomandibular dislocation	ORAL SURGERY	19
21493	Closed treatment of hyoid fracture; without manipulation	OTOLARYNGOLOGY	04
21494	Closed treatment of hyoid fracture; with manipulation	OTOLARYNGOLOGY	04
21495	Open treatment of hyoid fracture	OTOLARYNGOLOGY	04
21497	Interdental wiring, for condition other than fracture	ORAL SURGERY	19
21502	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax; with partial rib ostectomy	GENERAL SURGERY	02
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	THORACIC SURGERY	33
21610	Costotransversectomy (separate procedure)	NEUROSURGERY	14
21615	Excision first and/or cervical rib;	THORACIC SURGERY	33
21616	Excision first and/or cervical rib; with sympathectomy	THORACIC SURGERY	33
21632	Radical resection of sternum; with mediastinal lymphadenectomy	THORACIC SURGERY	33
21700	Division of scalenus anticus; without resection of cervical rib	VASCULAR SURGERY	77
21705	Division of scalenus anticus; with resection of cervical rib	VASCULAR SURGERY	77
21720	Division of sternocleidomastoid for torticollis, open operation; without cast application	NEUROSURGERY	14
21725	Division of sternocleidomastoid for torticollis, open operation; with cast application	ORTHOPEDIC SURGERY	20
21740	Reconstructive repair of pectus excavatum or carinatum; open	THORACIC SURGERY	33
21805	Open treatment of rib fracture without fixation, each	THORACIC SURGERY	33

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
21810	Treatment of rib fracture requiring external fixation (flail chest)	THORACIC SURGERY	33
21825	Open treatment of sternum fracture with or without skeletal fixation	THORACIC SURGERY	33
22100	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical	NEUROSURGERY	14
22101	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic	NEUROSURGERY	14
22110	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	NEUROSURGERY	14
22112	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic	NEUROSURGERY	14
22220	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; cervical	NEUROSURGERY	14
22222	Osteotomy of spine, including diskectomy, anterior approach, single vertebral segment; thoracic	NEUROSURGERY	14
22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting	NEUROSURGERY	14
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	NEUROSURGERY	14
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	ORTHOPEDIC SURGERY	20
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments	ORTHOPEDIC SURGERY	20
22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments	ORTHOPEDIC SURGERY	20
22847	Anterior instrumentation; 8 or more vertebral segments	ORTHOPEDIC SURGERY	20
23000	Removal of subdeltoid calcareous deposits, open	ORTHOPEDIC SURGERY	20
23100	Arthrotomy, glenohumeral joint, including biopsy	ORTHOPEDIC SURGERY	20
23106	Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy	ORTHOPEDIC SURGERY	20
23125	Claviculectomy; total	ORTHOPEDIC SURGERY	20
23145	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
23146	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft	ORTHOPEDIC SURGERY	20
23155	Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
23156	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft	ORTHOPEDIC SURGERY	20
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	ORTHOPEDIC SURGERY	20
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	ORTHOPEDIC SURGERY	20
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	ORTHOPEDIC SURGERY	20
23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), scapula	ORTHOPEDIC SURGERY	20
23190	Ostectomy of scapula, partial (eg, superior medial angle)	ORTHOPEDIC SURGERY	20
23195	Resection, humeral head	ORTHOPEDIC SURGERY	20
23200	Radical resection for tumor; clavicle	ORTHOPEDIC SURGERY	20
23210	Radical resection for tumor; scapula	ORTHOPEDIC SURGERY	20
23220	Radical resection of bone tumor, proximal humerus;	ORTHOPEDIC SURGERY	20
23221	Radical resection of bone tumor, proximal humerus; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
23222	Radical resection of bone tumor, proximal humerus; with prosthetic replacement	ORTHOPEDIC SURGERY	20
23397	Muscle transfer, any type, shoulder or upper arm; multiple	ORTHOPEDIC SURGERY	20
23400	Scapulopexy (eg, Sprengels deformity or for paralysis)	ORTHOPEDIC SURGERY	20
23406	Tenotomy, shoulder area; multiple tendons through same incision	ORTHOPEDIC SURGERY	20
23460	Capsulorrhaphy, anterior, any type; with bone block	ORTHOPEDIC SURGERY	20
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer	ORTHOPEDIC SURGERY	20
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	ORTHOPEDIC SURGERY	20
23480	Osteotomy, clavicle, with or without internal fixation;	ORTHOPEDIC SURGERY	20
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	ORTHOPEDIC SURGERY	20
23491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus	ORTHOPEDIC SURGERY	20
23520	Closed treatment of sternoclavicular dislocation; without manipulation	ORTHOPEDIC SURGERY	20
23525	Closed treatment of sternoclavicular dislocation; with manipulation	ORTHOPEDIC SURGERY	20
23530	Open treatment of sternoclavicular dislocation, acute or chronic;	ORTHOPEDIC SURGERY	20
23532	Open treatment of sternoclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
23545	Closed treatment of acromioclavicular dislocation; with manipulation	EMERGENCY MEDICINE	93
23552	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
23575	Closed treatment of scapular fracture; with manipulation, with or without skeletal traction (with or without shoulder joint involvement)	ORTHOPEDIC SURGERY	20
23800	Arthrodesis, glenohumeral joint;	ORTHOPEDIC SURGERY	20
23802	Arthrodesis, glenohumeral joint; with autogenous graft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
23900	Interthoracoscapular amputation (forequarter)	ORTHOPEDIC SURGERY	20
23920	Disarticulation of shoulder;	ORTHOPEDIC SURGERY	20
23921	Disarticulation of shoulder; secondary closure or scar revision	ORTHOPEDIC SURGERY	20
24100	Arthrotomy, elbow; with synovial biopsy only	ORTHOPEDIC SURGERY	20
24110	Excision or curettage of bone cyst or benign tumor, humerus;	ORTHOPEDIC SURGERY	20
24115	Excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
24116	Excision or curettage of bone cyst or benign tumor, humerus; with allograft	ORTHOPEDIC SURGERY	20
24125	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
24126	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with allograft	ORTHOPEDIC SURGERY	20
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	ORTHOPEDIC SURGERY	20
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	ORTHOPEDIC SURGERY	20
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	ORTHOPEDIC SURGERY	20
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	ORTHOPEDIC SURGERY	20
24150	Radical resection for tumor, shaft or distal humerus;	ORTHOPEDIC SURGERY	20
24151	Radical resection for tumor, shaft or distal humerus; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
24152	Radical resection for tumor, radial head or neck;	ORTHOPEDIC SURGERY	20
24153	Radical resection for tumor, radial head or neck; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
24155	Resection of elbow joint (arthrectomy)	ORTHOPEDIC SURGERY	20
24164	Implant removal; radial head	ORTHOPEDIC SURGERY	20
24301	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331)	ORTHOPEDIC SURGERY	20
24320	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)	ORTHOPEDIC SURGERY	20
24330	Flexor-plasty, elbow (eg, Steindler type advancement);	ORTHOPEDIC SURGERY	20
24331	Flexor-plasty, elbow (eg, Steindler type advancement); with extensor advancement	ORTHOPEDIC SURGERY	20
24332	Tenolysis, triceps	ORTHOPEDIC SURGERY	20
24340	Tenodesis of biceps tendon at elbow (separate procedure)	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
24344	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	ORTHOPEDIC SURGERY	20
24345	Repair medial collateral ligament, elbow, with local tissue	ORTHOPEDIC SURGERY	20
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	ORTHOPEDIC SURGERY	20
24352	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with annular ligament resection	ORTHOPEDIC SURGERY	20
24354	Fasciotomy, lateral or medial (eg, tennis elbow or epicondylitis); with stripping	ORTHOPEDIC SURGERY	20
24360	Arthroplasty, elbow; with membrane (eg, fascial)	ORTHOPEDIC SURGERY	20
24361	Arthroplasty, elbow; with distal humeral prosthetic replacement	ORTHOPEDIC SURGERY	20
24362	Arthroplasty, elbow; with implant and fascia lata ligament reconstruction	ORTHOPEDIC SURGERY	20
24365	Arthroplasty, radial head;	ORTHOPEDIC SURGERY	20
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	ORTHOPEDIC SURGERY	20
24420	Osteoplasty, humerus (eg, shortening or lengthening) (excluding 64876)	ORTHOPEDIC SURGERY	20
24470	Hemiepiphyseal arrest (eg, cubitus varus or valgus, distal humerus)	ORTHOPEDIC SURGERY	20
24565	Closed treatment of humeral epicondylar fracture, medial or lateral; with manipulation	ORTHOPEDIC SURGERY	20
24566	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation	ORTHOPEDIC SURGERY	20
24577	Closed treatment of humeral condylar fracture, medial or lateral; with manipulation	ORTHOPEDIC SURGERY	20
24582	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation	ORTHOPEDIC SURGERY	20
24587	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty	ORTHOPEDIC SURGERY	20
24640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation	EMERGENCY MEDICINE	93
24800	Arthrodesis, elbow joint; local	ORTHOPEDIC SURGERY	20
24802	Arthrodesis, elbow joint; with autogenous graft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
24920	Amputation, arm through humerus; open, circular (guillotine)	ORTHOPEDIC SURGERY	20
24925	Amputation, arm through humerus; secondary closure or scar revision	ORTHOPEDIC SURGERY	20
24930	Amputation, arm through humerus; re-amputation	ORTHOPEDIC SURGERY	20
24931	Amputation, arm through humerus; with implant	ORTHOPEDIC SURGERY	20
24935	Stump elongation, upper extremity	GENERAL SURGERY	02
25025	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve	ORTHOPEDIC SURGERY	20
25031	Incision and drainage, forearm and/or wrist; bursa	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
25085	Capsulotomy, wrist (eg, contracture)	ORTHOPEDIC SURGERY	20
25100	Arthrotomy, wrist joint; with biopsy	ORTHOPEDIC SURGERY	20
25107	Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex	ORTHOPEDIC SURGERY	20
25119	Synovectomy, extensor tendon sheath, wrist, single compartment; with resection of distal ulna	ORTHOPEDIC SURGERY	20
25125	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
25126	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft	ORTHOPEDIC SURGERY	20
25135	Excision or curettage of bone cyst or benign tumor of carpal bones; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
25136	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft	ORTHOPEDIC SURGERY	20
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist	ORTHOPEDIC SURGERY	20
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	ORTHOPEDIC SURGERY	20
25170	Radical resection for tumor, radius or ulna	ORTHOPEDIC SURGERY	20
25250	Removal of wrist prosthesis; (separate procedure)	ORTHOPEDIC SURGERY	20
25251	Removal of wrist prosthesis; complicated, including total wrist	ORTHOPEDIC SURGERY	20
25263	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, single, each tendon or muscle	ORTHOPEDIC SURGERY	20
25265	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle	ORTHOPEDIC SURGERY	20
25275	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	ORTHOPEDIC SURGERY	20
25300	Tenodesis at wrist; flexors of fingers	ORTHOPEDIC SURGERY	20
25315	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist;	ORTHOPEDIC SURGERY	20
25316	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist; with tendon(s) transfer	ORTHOPEDIC SURGERY	20
25335	Centralization of wrist on ulna (eg, radial club hand)	ORTHOPEDIC SURGERY	20
25355	Osteotomy, radius; middle or proximal third	ORTHOPEDIC SURGERY	20
25365	Osteotomy; radius AND ulna	ORTHOPEDIC SURGERY	20
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
25375	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna	ORTHOPEDIC SURGERY	20
25391	Osteoplasty, radius OR ulna; lengthening with autograft	ORTHOPEDIC SURGERY	20
25392	Osteoplasty, radius AND ulna; shortening (excluding 64876)	ORTHOPEDIC SURGERY	20
25393	Osteoplasty, radius AND ulna; lengthening with autograft	ORTHOPEDIC SURGERY	20
25394	Osteoplasty, carpal bone, shortening	ORTHOPEDIC SURGERY	20
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	ORTHOPEDIC SURGERY	20
25420	Repair of nonunion or malunion, radius AND ulna; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
25425	Repair of defect with autograft; radius OR ulna	ORTHOPEDIC SURGERY	20
25426	Repair of defect with autograft; radius AND ulna	ORTHOPEDIC SURGERY	20
25430	Insertion of vascular pedicle into carpal bone (eg, Hori procedure)	ORTHOPEDIC SURGERY	20
25431	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone	ORTHOPEDIC SURGERY	20
25441	Arthroplasty with prosthetic replacement; distal radius	ORTHOPEDIC SURGERY	20
25442	Arthroplasty with prosthetic replacement; distal ulna	ORTHOPEDIC SURGERY	20
25443	Arthroplasty with prosthetic replacement; scaphoid carpal (navicular)	ORTHOPEDIC SURGERY	20
25444	Arthroplasty with prosthetic replacement; lunate	ORTHOPEDIC SURGERY	20
25449	Revision of arthroplasty, including removal of implant, wrist joint	ORTHOPEDIC SURGERY	20
25450	Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna	ORTHOPEDIC SURGERY	20
25455	Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna	ORTHOPEDIC SURGERY	20
25490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius	ORTHOPEDIC SURGERY	20
25491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; ulna	ORTHOPEDIC SURGERY	20
25492	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; radius AND ulna	ORTHOPEDIC SURGERY	20
25520	Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)	ORTHOPEDIC SURGERY	20
25526	Open treatment of radial shaft fracture, with internal and/or external fixation and open treatment, with or without internal or external fixation of distal radioulnar joint (Galeazzi fracture/dislocation), includes repair of triangular fibrocartilage complex	ORTHOPEDIC SURGERY	20
25635	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); with manipulation, each bone	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
25645	Open treatment of carpal bone fracture (other than carpal scaphoid (navicular)), each bone	ORTHOPEDIC SURGERY	20
25651	Percutaneous skeletal fixation of ulnar styloid fracture	ORTHOPEDIC SURGERY	20
25671	Percutaneous skeletal fixation of distal radioulnar dislocation	ORTHOPEDIC SURGERY	20
25676	Open treatment of distal radioulnar dislocation, acute or chronic	ORTHOPEDIC SURGERY	20
25685	Open treatment of trans-scaphoperilunar type of fracture dislocation	ORTHOPEDIC SURGERY	20
25690	Closed treatment of lunate dislocation, with manipulation	ORTHOPEDIC SURGERY	20
25695	Open treatment of lunate dislocation	ORTHOPEDIC SURGERY	20
25805	Arthrodesis, wrist; with sliding graft	ORTHOPEDIC SURGERY	20
25830	Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (eg, Sauve-Kapandji procedure)	ORTHOPEDIC SURGERY	20
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	ORTHOPEDIC SURGERY	20
25907	Amputation, forearm, through radius and ulna; secondary closure or scar revision	ORTHOPEDIC SURGERY	20
25909	Amputation, forearm, through radius and ulna; re-amputation	ORTHOPEDIC SURGERY	20
25915	Krukenberg procedure	ORTHOPEDIC SURGERY	20
25920	Disarticulation through wrist;	ORTHOPEDIC SURGERY	20
25922	Disarticulation through wrist; secondary closure or scar revision	ORTHOPEDIC SURGERY	20
25924	Disarticulation through wrist; re-amputation	ORTHOPEDIC SURGERY	20
25927	Transmetacarpal amputation;	ORTHOPEDIC SURGERY	20
25929	Transmetacarpal amputation; secondary closure or scar revision	ORTHOPEDIC SURGERY	20
25931	Transmetacarpal amputation; re-amputation	ORTHOPEDIC SURGERY	20
26035	Decompression fingers and/or hand, injection injury (eg, grease gun)	ORTHOPEDIC SURGERY	20
26100	Arthrotomy with biopsy; carpometacarpal joint, each	ORTHOPEDIC SURGERY	20
26105	Arthrotomy with biopsy; metacarpophalangeal joint, each	ORTHOPEDIC SURGERY	20
26185	Sesamoidectomy, thumb or finger (separate procedure)	ORTHOPEDIC SURGERY	20
26205	Excision or curettage of bone cyst or benign tumor of metacarpal; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
26215	Excision or curettage of bone cyst or benign tumor of proximal, middle, or distal phalanx of finger; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
26250	Radical resection, metacarpal (eg, tumor);	ORTHOPEDIC SURGERY	20
26255	Radical resection, metacarpal (eg, tumor); with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
26260	Radical resection, proximal or middle phalanx of finger (eg, tumor);	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
26261	Radical resection, proximal or middle phalanx of finger (eg, tumor); with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
26262	Radical resection, distal phalanx of finger (eg, tumor)	ORTHOPEDIC SURGERY	20
26352	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); secondary with free graft (includes obtaining graft), each tendon	ORTHOPEDIC SURGERY	20
26357	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon	ORTHOPEDIC SURGERY	20
26358	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon	ORTHOPEDIC SURGERY	20
26372	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft (includes obtaining graft), each tendon	ORTHOPEDIC SURGERY	20
26373	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary without free graft, each tendon	ORTHOPEDIC SURGERY	20
26390	Excision flexor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	ORTHOPEDIC SURGERY	20
26392	Removal of synthetic rod and insertion of flexor tendon graft, hand or finger (includes obtaining graft), each rod	ORTHOPEDIC SURGERY	20
26415	Excision of extensor tendon, with implantation of synthetic rod for delayed tendon graft, hand or finger, each rod	ORTHOPEDIC SURGERY	20
26416	Removal of synthetic rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger, each rod	ORTHOPEDIC SURGERY	20
26420	Repair, extensor tendon, finger, primary or secondary; with free graft (includes obtaining graft) each tendon	ORTHOPEDIC SURGERY	20
26428	Repair of extensor tendon, central slip, secondary (eg, boutonniere deformity); with free graft (includes obtaining graft), each finger	ORTHOPEDIC SURGERY	20
26434	Repair of extensor tendon, distal insertion, primary or secondary; with free graft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
26474	Tenodesis; of distal joint, each joint	ORTHOPEDIC SURGERY	20
26476	Lengthening of tendon, extensor, hand or finger, each tendon	ORTHOPEDIC SURGERY	20
26479	Shortening of tendon, flexor, hand or finger, each tendon	ORTHOPEDIC SURGERY	20
26489	Transfer or transplant of tendon, palmar; with free tendon graft (includes obtaining graft), each tendon	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
26492	Opponensplasty; tendon transfer with graft (includes obtaining graft), each tendon	ORTHOPEDIC SURGERY	20
26494	Opponensplasty; hypothenar muscle transfer	ORTHOPEDIC SURGERY	20
26497	Transfer of tendon to restore intrinsic function; ring and small finger	ORTHOPEDIC SURGERY	20
26498	Transfer of tendon to restore intrinsic function; all four fingers	ORTHOPEDIC SURGERY	20
26499	Correction claw finger, other methods	ORTHOPEDIC SURGERY	20
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	ORTHOPEDIC SURGERY	20
26504	Reconstruction of tendon pulley, each tendon; with tendon prosthesis (separate procedure)	ORTHOPEDIC SURGERY	20
26517	Capsulodesis, metacarpophalangeal joint; two digits	ORTHOPEDIC SURGERY	20
26518	Capsulodesis, metacarpophalangeal joint; three or four digits	ORTHOPEDIC SURGERY	20
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	ORTHOPEDIC SURGERY	20
26546	Repair non-union, metacarpal or phalanx, (includes obtaining bone graft with or without external or internal fixation)	ORTHOPEDIC SURGERY	20
26550	Pollicization of a digit	ORTHOPEDIC SURGERY	20
26551	Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graft	ORTHOPEDIC SURGERY	20
26553	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single	ORTHOPEDIC SURGERY	20
26554	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double	ORTHOPEDIC SURGERY	20
26555	Transfer, finger to another position without microvascular anastomosis	ORTHOPEDIC SURGERY	20
26556	Transfer, free toe joint, with microvascular anastomosis	ORTHOPEDIC SURGERY	24
26560	Repair of syndactyly (web finger) each web space; with skin flaps	ORTHOPEDIC SURGERY	20
26561	Repair of syndactyly (web finger) each web space; with skin flaps and grafts	ORTHOPEDIC SURGERY	20
26562	Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails)	ORTHOPEDIC SURGERY	20
26565	Osteotomy; metacarpal, each	ORTHOPEDIC SURGERY	20
26568	Osteoplasty, lengthening, metacarpal or phalanx	ORTHOPEDIC SURGERY	20
26580	Repair cleft hand	ORTHOPEDIC SURGERY	20
26587	Reconstruction of polydactylous digit, soft tissue and bone	ORTHOPEDIC SURGERY	20
26590	Repair macrodactylia, each digit	ORTHOPEDIC SURGERY	20
26596	Excision of constricting ring of finger, with multiple Z-plasties	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation	ORTHOPEDIC SURGERY	20
26675	Closed treatment of carpometacarpal dislocation, other than thumb, with manipulation, each joint; requiring anesthesia	ORTHOPEDIC SURGERY	20
26685	Open treatment of carpometacarpal dislocation, other than thumb; with or without internal or external fixation, each joint	ORTHOPEDIC SURGERY	20
26686	Open treatment of carpometacarpal dislocation, other than thumb; complex, multiple or delayed reduction	ORTHOPEDIC SURGERY	20
26706	Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation	ORTHOPEDIC SURGERY	20
26820	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
26843	Arthrodesis, carpometacarpal joint, digit, other than thumb, each;	ORTHOPEDIC SURGERY	20
26844	Arthrodesis, carpometacarpal joint, digit, other than thumb, each; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
26863	Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint (List separately in addition to code for primary procedure)	ORTHOPEDIC SURGERY	20
27003	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy	ORTHOPEDIC SURGERY	20
27005	Tenotomy, hip flexor(s), open (separate procedure)	ORTHOPEDIC SURGERY	20
27035	Denervation, hip joint, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral, or obturator nerves	PLASTIC AND RECONSTUCTIVE SURGERY	24
27050	Arthrotomy, with biopsy; sacroiliac joint	ORTHOPEDIC SURGERY	20
27060	Excision; ischial bursa	PLASTIC AND RECONSTUCTIVE SURGERY	24
27067	Excision of bone cyst or benign tumor; with autograft requiring separate incision	ORTHOPEDIC SURGERY	20
27075	Radical resection of tumor or infection; wing of ilium, one pubic or ischial ramus or symphysis pubis	ORTHOPEDIC SURGERY	20
27077	Radical resection of tumor or infection; innominate bone, total	ORTHOPEDIC SURGERY	20
27078	Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur	ORTHOPEDIC SURGERY	20
27079	Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur, with skin flaps	GENERAL SURGERY	02
27097	Release or recession, hamstring, proximal	ORTHOPEDIC SURGERY	20
27098	Transfer, adductor to ischium	ORTHOPEDIC SURGERY	20
27100	Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
27105	Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)	ORTHOPEDIC SURGERY	20
27110	Transfer iliopsoas; to greater trochanter of femur	ORTHOPEDIC SURGERY	20
27111	Transfer iliopsoas; to femoral neck	ORTHOPEDIC SURGERY	20
27120	Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type)	ORTHOPEDIC SURGERY	20
27146	Osteotomy, iliac, acetabular or innominate bone;	ORTHOPEDIC SURGERY	20
27147	Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip	ORTHOPEDIC SURGERY	20
27151	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy	ORTHOPEDIC SURGERY	20
27156	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip	ORTHOPEDIC SURGERY	20
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	ORTHOPEDIC SURGERY	20
27161	Osteotomy, femoral neck (separate procedure)	ORTHOPEDIC SURGERY	20
27175	Treatment of slipped femoral epiphysis; by traction, without reduction	ORTHOPEDIC SURGERY	20
27176	Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ	ORTHOPEDIC SURGERY	20
27177	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
27178	Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning	ORTHOPEDIC SURGERY	20
27179	Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)	ORTHOPEDIC SURGERY	20
27181	Open treatment of slipped femoral epiphysis; osteotomy and internal fixation	ORTHOPEDIC SURGERY	20
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur	ORTHOPEDIC SURGERY	20
27202	Open treatment of coccygeal fracture	ORTHOPEDIC SURGERY	20
27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s) (eg, pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation	ORTHOPEDIC SURGERY	20
27258	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);	ORTHOPEDIC SURGERY	20
27259	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening	ORTHOPEDIC SURGERY	20
27280	Arthrodesis, sacroiliac joint (including obtaining graft)	ORTHOPEDIC SURGERY	20
27282	Arthrodesis, symphysis pubis (including obtaining graft)	ORTHOPEDIC SURGERY	20
27284	Arthrodesis, hip joint (including obtaining graft);	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
27286	Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy	ORTHOPEDIC SURGERY	20
27290	Interpelviabdominal amputation (hindquarter amputation)	ORTHOPEDIC SURGERY	20
27306	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)	ORTHOPEDIC SURGERY	20
27307	Tenotomy, percutaneous, adductor or hamstring; multiple tendons	ORTHOPEDIC SURGERY	20
27315	Neurectomy, hamstring muscle	ORTHOPEDIC SURGERY	20
27320	Neurectomy, popliteal (gastrocnemius)	ORTHOPEDIC SURGERY	20
27330	Arthrotomy, knee; with synovial biopsy only	ORTHOPEDIC SURGERY	20
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	ORTHOPEDIC SURGERY	20
27358	Excision or curettage of bone cyst or benign tumor of femur; with internal fixation (List in addition to code for primary procedure)	ORTHOPEDIC SURGERY	20
27390	Tenotomy, open, hamstring, knee to hip; single tendon	ORTHOPEDIC SURGERY	20
27391	Tenotomy, open, hamstring, knee to hip; multiple tendons, one leg	ORTHOPEDIC SURGERY	20
27392	Tenotomy, open, hamstring, knee to hip; multiple tendons, bilateral	ORTHOPEDIC SURGERY	20
27393	Lengthening of hamstring tendon; single tendon	ORTHOPEDIC SURGERY	20
27395	Lengthening of hamstring tendon; multiple tendons, bilateral	ORTHOPEDIC SURGERY	20
27396	Transplant, hamstring tendon to patella; single tendon	ORTHOPEDIC SURGERY	20
27397	Transplant, hamstring tendon to patella; multiple tendons	ORTHOPEDIC SURGERY	20
27400	Transfer, tendon or muscle, hamstrings to femur (eg, Egger's type procedure)	ORTHOPEDIC SURGERY	20
27407	Repair, primary, torn ligament and/or capsule, knee; cruciate	ORTHOPEDIC SURGERY	20
27409	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments	ORTHOPEDIC SURGERY	20
27424	Reconstruction of dislocating patella; with patellectomy	ORTHOPEDIC SURGERY	20
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)	ORTHOPEDIC SURGERY	20
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular	ORTHOPEDIC SURGERY	20
27440	Arthroplasty, knee, tibial plateau;	ORTHOPEDIC SURGERY	20
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	ORTHOPEDIC SURGERY	20
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	ORTHOPEDIC SURGERY	20
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	ORTHOPEDIC SURGERY	20
27454	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure)	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
27455	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus (bowleg) or genu valgus (knock-knee)); before epiphyseal closure	ORTHOPEDIC SURGERY	20
27465	Osteoplasty, femur; shortening (excluding 64876)	ORTHOPEDIC SURGERY	20
27466	Osteoplasty, femur; lengthening	ORTHOPEDIC SURGERY	20
27468	Osteoplasty, femur; combined, lengthening and shortening with femoral segment transfer	ORTHOPEDIC SURGERY	20
27475	Arrest, epiphyseal, any method (eg, epiphysiodesis); distal femur	ORTHOPEDIC SURGERY	20
27477	Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal	ORTHOPEDIC SURGERY	20
27479	Arrest, epiphyseal, any method (eg, epiphysiodesis); combined distal femur, proximal tibia and fibula	ORTHOPEDIC SURGERY	20
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)	ORTHOPEDIC SURGERY	20
27496	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);	ORTHOPEDIC SURGERY	20
27497	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve	ORTHOPEDIC SURGERY	20
27498	Decompression fasciotomy, thigh and/or knee, multiple compartments;	ORTHOPEDIC SURGERY	20
27499	Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve	ORTHOPEDIC SURGERY	20
27516	Closed treatment of distal femoral epiphyseal separation; without manipulation	ORTHOPEDIC SURGERY	20
27517	Closed treatment of distal femoral epiphyseal separation; with manipulation, with or without skin or skeletal traction	ORTHOPEDIC SURGERY	20
27519	Open treatment of distal femoral epiphyseal separation, with or without internal or external fixation	ORTHOPEDIC SURGERY	20
27556	Open treatment of knee dislocation, with or without internal or external fixation; without primary ligamentous repair or augmentation/reconstruction	ORTHOPEDIC SURGERY	20
27557	Open treatment of knee dislocation, with or without internal or external fixation; with primary ligamentous repair	ORTHOPEDIC SURGERY	20
27558	Open treatment of knee dislocation, with or without internal or external fixation; with primary ligamentous repair, with augmentation/reconstruction	ORTHOPEDIC SURGERY	20
27562	Closed treatment of patellar dislocation; requiring anesthesia	ORTHOPEDIC SURGERY	20
27566	Open treatment of patellar dislocation, with or without partial or total patellectomy	ORTHOPEDIC SURGERY	20
27637	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
27638	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
27645	Radical resection of tumor, bone; tibia	ORTHOPEDIC SURGERY	20
27646	Radical resection of tumor, bone; fibula	ORTHOPEDIC SURGERY	20
27656	Repair, fascial defect of leg	ORTHOPEDIC SURGERY	20
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	ORTHOPEDIC SURGERY	20
27676	Repair, dislocating peroneal tendons; with fibular osteotomy	ORTHOPEDIC SURGERY	20
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision(s))	ORTHOPEDIC SURGERY	20
27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	ORTHOPEDIC SURGERY	20
27700	Arthroplasty, ankle;	ORTHOPEDIC SURGERY	20
27703	Arthroplasty, ankle; revision, total ankle	ORTHOPEDIC SURGERY	20
27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)	ORTHOPEDIC SURGERY	20
27715	Osteoplasty, tibia and fibula, lengthening or shortening	ORTHOPEDIC SURGERY	20
27722	Repair of nonunion or malunion, tibia; with sliding graft	ORTHOPEDIC SURGERY	20
27725	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method	ORTHOPEDIC SURGERY	20
27727	Repair of congenital pseudarthrosis, tibia	ORTHOPEDIC SURGERY	20
27730	Arrest, epiphyseal (epiphysiodesis), open; distal tibia	ORTHOPEDIC SURGERY	20
27732	Arrest, epiphyseal (epiphysiodesis), open; distal fibula	ORTHOPEDIC SURGERY	20
27734	Arrest, epiphyseal (epiphysiodesis), open; distal tibia and fibula	ORTHOPEDIC SURGERY	20
27740	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula;	ORTHOPEDIC SURGERY	20
27742	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; and distal femur	ORTHOPEDIC SURGERY	20
27830	Closed treatment of proximal tibiofibular joint dislocation; without anesthesia	ORTHOPEDIC SURGERY	20
27831	Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia	ORTHOPEDIC SURGERY	20
27832	Open treatment of proximal tibiofibular joint dislocation, with or without internal or external fixation, or with excision of proximal fibula	ORTHOPEDIC SURGERY	20
27893	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve	ORTHOPEDIC SURGERY	20
28050	Arthrotomy with biopsy; intertarsal or tarsometatarsal joint	PODIATRY	48
28054	Arthrotomy with biopsy; interphalangeal joint	PODIATRY	48
28102	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
28103	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft	PODIATRY	48

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
28106	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)	PODIATRY	48
28107	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft	PODIATRY	48
28130	Talectomy (astragalectomy)	ORTHOPEDIC SURGERY	20
28171	Radical resection of tumor, bone; tarsal (except talus or calcaneus)	ORTHOPEDIC SURGERY	20
28202	Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)	PODIATRY	48
28210	Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft)	PODIATRY	48
28262	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)	ORTHOPEDIC SURGERY	20
28264	Capsulotomy, midtarsal (eg, Heyman type procedure)	ORTHOPEDIC SURGERY	20
28302	Osteotomy; talus	ORTHOPEDIC SURGERY	20
28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	PODIATRY	48
28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	ORTHOPEDIC SURGERY	20
28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	ORTHOPEDIC SURGERY	20
28340	Reconstruction, toe, macrodactyly; soft tissue resection	PODIATRY	48
28341	Reconstruction, toe, macrodactyly; requiring bone resection	PODIATRY	48
28344	Reconstruction, toe(s); polydactyly	PODIATRY	48
28345	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web	PODIATRY	48
28360	Reconstruction, cleft foot	ORTHOPEDIC SURGERY	20
28420	Open treatment of calcaneal fracture, with or without internal or external fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)	ORTHOPEDIC SURGERY	20
28435	Closed treatment of talus fracture; with manipulation	ORTHOPEDIC SURGERY	20
28436	Percutaneous skeletal fixation of talus fracture, with manipulation	ORTHOPEDIC SURGERY	20
28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	ORTHOPEDIC SURGERY	20
28531	Open treatment of sesamoid fracture, with or without internal fixation	PODIATRY	48
28545	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia	ORTHOPEDIC SURGERY	20
28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
28570	Closed treatment of talotarsal joint dislocation; without anesthesia	PODIATRY	48
28575	Closed treatment of talotarsal joint dislocation; requiring anesthesia	ORTHOPEDIC SURGERY	20
28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	ORTHOPEDIC SURGERY	20
28605	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia	ORTHOPEDIC SURGERY	20
28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	ORTHOPEDIC SURGERY	20
28666	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation	ORTHOPEDIC SURGERY	20
29000	Application of halo type body cast (see 20661-20663 for insertion)	NEUROSURGERY	14
29010	Application of Risser jacket, localizer, body; only	ORTHOPEDIC SURGERY	20
29015	Application of Risser jacket, localizer, body; including head	ORTHOPEDIC SURGERY	20
29020	Application of turnbuckle jacket, body; only	ORTHOPEDIC SURGERY	20
29025	Application of turnbuckle jacket, body; including head	ORTHOPEDIC SURGERY	20
29035	Application of body cast, shoulder to hips;	ORTHOPEDIC SURGERY	20
29040	Application of body cast, shoulder to hips; including head, Minerva type	ORTHOPEDIC SURGERY	20
29044	Application of body cast, shoulder to hips; including one thigh	ORTHOPEDIC SURGERY	20
29046	Application of body cast, shoulder to hips; including both thighs	ORTHOPEDIC SURGERY	20
29049	Application, cast; figure-of-eight	ORTHOPEDIC SURGERY	20
29055	Application, cast; shoulder spica	ORTHOPEDIC SURGERY	20
29305	Application of hip spica cast; one leg	ORTHOPEDIC SURGERY	20
29325	Application of hip spica cast; one and one-half spica or both legs	ORTHOPEDIC SURGERY	20
29710	Removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.	ORTHOPEDIC SURGERY	20
29715	Removal or bivalving; turnbuckle jacket	ORTHOPEDIC SURGERY	20
29750	Wedging of clubfoot cast	ORTHOPEDIC SURGERY	20
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	ORTHOPEDIC SURGERY	20
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)	ORTHOPEDIC SURGERY	20
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body	ORTHOPEDIC SURGERY	20
29835	Arthroscopy, elbow, surgical; synovectomy, partial	ORTHOPEDIC SURGERY	20
29836	Arthroscopy, elbow, surgical; synovectomy, complete	ORTHOPEDIC SURGERY	20
29837	Arthroscopy, elbow, surgical; debridement, limited	ORTHOPEDIC SURGERY	20
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)	ORTHOPEDIC SURGERY	20
29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
29844	Arthroscopy, wrist, surgical; synovectomy, partial	ORTHOPEDIC SURGERY	20
29847	Arthroscopy, wrist, surgical; internal fixation for fracture or instability	ORTHOPEDIC SURGERY	20
29850	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	ORTHOPEDIC SURGERY	20
29851	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)	ORTHOPEDIC SURGERY	20
29856	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)	ORTHOPEDIC SURGERY	20
29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)	ORTHOPEDIC SURGERY	20
29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body	ORTHOPEDIC SURGERY	20
29863	Arthroscopy, hip, surgical; with synovectomy	ORTHOPEDIC SURGERY	20
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)	ORTHOPEDIC SURGERY	20
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	ORTHOPEDIC SURGERY	20
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	ORTHOPEDIC SURGERY	20
29900	Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy	ORTHOPEDIC SURGERY	20
29901	Arthroscopy, metacarpophalangeal joint, surgical; with debridement	ORTHOPEDIC SURGERY	20
29902	Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stenar lesion)	ORTHOPEDIC SURGERY	20
30125	Excision dermoid cyst, nose; complex, under bone or cartilage	OTOLARYNGOLOGY	04
30160	Rhinectomy; total	OTOLARYNGOLOGY	04
30320	Removal foreign body, intranasal; by lateral rhinotomy	OTOLARYNGOLOGY	04
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	OTOLARYNGOLOGY	04
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	OTOLARYNGOLOGY	04
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	OTOLARYNGOLOGY	04
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	OTOLARYNGOLOGY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	PLASTIC AND RECONSTUCTIVE SURGERY	24
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	PLASTIC AND RECONSTUCTIVE SURGERY	24
30540	Repair choanal atresia; intranasal	OTOLARYNGOLOGY	04
30545	Repair choanal atresia; transpalatine	OTOLARYNGOLOGY	04
30600	Repair fistula; oronasal	ORAL SURGERY	19
31002	Lavage by cannulation; sphenoid sinus	OTOLARYNGOLOGY	04
31040	Pterygomaxillary fossa surgery, any approach	OTOLARYNGOLOGY	04
31080	Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation)	OTOLARYNGOLOGY	04
31081	Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)	OTOLARYNGOLOGY	04
31084	Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision	OTOLARYNGOLOGY	04
31086	Sinusotomy frontal; nonobliterative, with osteoplastic flap, brow incision	OTOLARYNGOLOGY	04
31087	Sinusotomy frontal; nonobliterative, with osteoplastic flap, coronal incision	OTOLARYNGOLOGY	04
31230	Maxillectomy; with orbital exenteration (en bloc)	OTOLARYNGOLOGY	04
31291	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region	OTOLARYNGOLOGY	04
31293	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression	OTOLARYNGOLOGY	04
31294	Nasal/sinus endoscopy, surgical; with optic nerve decompression	OTOLARYNGOLOGY	04
31320	Laryngotomy (thyrotomy, laryngofissure); diagnostic	OTOLARYNGOLOGY	04
31367	Laryngectomy; subtotal supraglottic, without radical neck dissection	OTOLARYNGOLOGY	04
31368	Laryngectomy; subtotal supraglottic, with radical neck dissection	OTOLARYNGOLOGY	04
31370	Partial laryngectomy (hemilaryngectomy); horizontal	OTOLARYNGOLOGY	04
31375	Partial laryngectomy (hemilaryngectomy); laterovertical	OTOLARYNGOLOGY	04
31380	Partial laryngectomy (hemilaryngectomy); anterovertical	OTOLARYNGOLOGY	04
31382	Partial laryngectomy (hemilaryngectomy); antero-latero-vertical	OTOLARYNGOLOGY	04
31395	Pharyngolaryngectomy, with radical neck dissection; with reconstruction	OTOLARYNGOLOGY	04
31420	Epiglottidectomy	OTOLARYNGOLOGY	04
31512	Laryngoscopy, indirect; with removal of lesion	OTOLARYNGOLOGY	04
31520	Laryngoscopy direct, with or without tracheoscopy; diagnostic, newborn	OTOLARYNGOLOGY	04
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator	OTOLARYNGOLOGY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	OTOLARYNGOLOGY	04
31560	Laryngoscopy, direct, operative, with arytenoidectomy;	OTOLARYNGOLOGY	04
31578	Laryngoscopy, flexible fiberoptic; with removal of lesion	OTOLARYNGOLOGY	04
31580	Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal	OTOLARYNGOLOGY	04
31584	Laryngoplasty; with open reduction of fracture	OTOLARYNGOLOGY	04
31585	Treatment of closed laryngeal fracture; without manipulation	OTOLARYNGOLOGY	04
31586	Treatment of closed laryngeal fracture; with closed manipulative reduction	OTOLARYNGOLOGY	04
31587	Laryngoplasty, cricoid split	OTOLARYNGOLOGY	04
31590	Laryngeal reinnervation by neuromuscular pedicle	OTOLARYNGOLOGY	04
31595	Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral	OTOLARYNGOLOGY	04
31601	Tracheostomy, planned (separate procedure); under two years	OTOLARYNGOLOGY	04
31656	Bronchoscopy, (rigid or flexible); with injection of contrast material for segmental bronchography (fiberscope only)	PULMONARY DISEASE	29
31700	Catheterization, transglottic (separate procedure)	PULMONARY DISEASE	29
31708	Instillation of contrast material for laryngography or bronchography, without catheterization	PULMONARY DISEASE	29
31710	Catheterization for bronchography, with or without instillation of contrast material	PULMONARY DISEASE	29
31715	Transtracheal injection for bronchography	PULMONARY DISEASE	29
31717	Catheterization with bronchial brush biopsy	PULMONARY DISEASE	29
31755	Tracheoplasty; tracheopharyngeal fistulization, each stage	OTOLARYNGOLOGY	04
31760	Tracheoplasty; intrathoracic	THORACIC SURGERY	33
31766	Carinal reconstruction	THORACIC SURGERY	33
31770	Bronchoplasty; graft repair	THORACIC SURGERY	33
31775	Bronchoplasty; excision stenosis and anastomosis	THORACIC SURGERY	33
31780	Excision tracheal stenosis and anastomosis; cervical	OTOLARYNGOLOGY	04
31781	Excision tracheal stenosis and anastomosis; cervicothoracic	OTOLARYNGOLOGY	04
31785	Excision of tracheal tumor or carcinoma; cervical	OTOLARYNGOLOGY	04
31786	Excision of tracheal tumor or carcinoma; thoracic	THORACIC SURGERY	33
31800	Suture of tracheal wound or injury; cervical	OTOLARYNGOLOGY	04
31805	Suture of tracheal wound or injury; intrathoracic	THORACIC SURGERY	33
32151	Thoracotomy, major; with removal of intrapulmonary foreign body	THORACIC SURGERY	33
32200	Pneumonostomy; with open drainage of abscess or cyst	THORACIC SURGERY	33
32442	Removal of lung, total pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	THORACIC SURGERY	33

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
32491	Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure	THORACIC SURGERY	33
32522	Resection of lung; with reconstruction of chest wall, without prosthesis	THORACIC SURGERY	33
32603	Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy	THORACIC SURGERY	33
32604	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy	THORACIC SURGERY	33
32605	Thoracoscopy, diagnostic (separate procedure); mediastinal space, without biopsy	THORACIC SURGERY	33
32654	Thoracoscopy, surgical; with control of traumatic hemorrhage	THORACIC SURGERY	33
32658	Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac	THORACIC SURGERY	33
32660	Thoracoscopy, surgical; with total pericardiectomy	THORACIC SURGERY	33
32661	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass	THORACIC SURGERY	33
32665	Thoracoscopy, surgical; with esophagomyotomy (Heller type)	THORACIC SURGERY	33
32800	Repair lung hernia through chest wall	THORACIC SURGERY	33
32810	Closure of chest wall following open flap drainage for empyema (Clagett type procedure)	THORACIC SURGERY	33
32820	Major reconstruction, chest wall (posttraumatic)	THORACIC SURGERY	33
32852	Lung transplant, single; with cardiopulmonary bypass	THORACIC SURGERY	33
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	THORACIC SURGERY	33
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	THORACIC SURGERY	33
32905	Thoracoplasty, Schede type or extrapleural (all stages);	THORACIC SURGERY	33
32906	Thoracoplasty, Schede type or extrapleural (all stages); with closure of bronchopleural fistula	THORACIC SURGERY	33
32940	Pneumonolysis, extraperiosteal, including filling or packing procedures	THORACIC SURGERY	33
32960	Pneumothorax, therapeutic, intrapleural injection of air	DIAGNOSTIC RADIOLOGY	30
32997	Total lung lavage (unilateral)	PULMONARY DISEASE	29
33050	Excision of pericardial cyst or tumor	THORACIC SURGERY	33
33130	Resection of external cardiac tumor	CARDIAC SURGERY	78
33236	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular	CARDIAC SURGERY	78
33237	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; dual lead system	CARDIAC SURGERY	78
33238	Removal of permanent transvenous electrode(s) by thoracotomy	CARDIAC SURGERY	78

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
33250	Operative ablation of supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci); without cardiopulmonary bypass	CARDIAC SURGERY	78
33261	Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass	CARDIAC SURGERY	78
33310	Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass	CARDIAC SURGERY	78
33321	Suture repair of aorta or great vessels; with shunt bypass	CARDIAC SURGERY	78
33330	Insertion of graft, aorta or great vessels; without shunt, or cardiopulmonary bypass	THORACIC SURGERY	33
33332	Insertion of graft, aorta or great vessels; with shunt bypass	CARDIAC SURGERY	78
33401	Valvuloplasty, aortic valve; open, with inflow occlusion	CARDIAC SURGERY	78
33403	Valvuloplasty, aortic valve; using transventricular dilation, with cardiopulmonary bypass	CARDIAC SURGERY	78
33404	Construction of apical-aortic conduit	CARDIAC SURGERY	78
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	CARDIAC SURGERY	78
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	CARDIAC SURGERY	78
33414	Repair of left ventricular outflow tract obstruction by patch enlargement of the outflow tract	CARDIAC SURGERY	33
33415	Resection or incision of subvalvular tissue for discrete subvalvular aortic stenosis	CARDIAC SURGERY	78
33420	Valvotomy, mitral valve; closed heart	CARDIAC SURGERY	78
33422	Valvotomy, mitral valve; open heart, with cardiopulmonary bypass	CARDIAC SURGERY	78
33460	Valvectomy, tricuspid valve, with cardiopulmonary bypass	CARDIAC SURGERY	78
33468	Tricuspid valve repositioning and plication for Ebstein anomaly	CARDIAC SURGERY	78
33470	Valvotomy, pulmonary valve, closed heart; transventricular	CARDIAC SURGERY	78
33471	Valvotomy, pulmonary valve, closed heart; via pulmonary artery	CARDIAC SURGERY	78
33472	Valvotomy, pulmonary valve, open heart; with inflow occlusion	CARDIAC SURGERY	78
33474	Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass	CARDIAC SURGERY	78
33475	Replacement, pulmonary valve	CARDIAC SURGERY	78
33476	Right ventricular resection for infundibular stenosis, with or without commissurotomy	CARDIAC SURGERY	78
33478	Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection	CARDIAC SURGERY	78
33496	Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)	CARDIAC SURGERY	78

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
33500	Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardiopulmonary bypass	CARDIAC SURGERY	78
33501	Repair of coronary arteriovenous or arteriocardiac chamber fistula; without cardiopulmonary bypass	CARDIAC SURGERY	78
33502	Repair of anomalous coronary artery; by ligation	CARDIAC SURGERY	78
33503	Repair of anomalous coronary artery; by graft, without cardiopulmonary bypass	CARDIAC SURGERY	78
33504	Repair of anomalous coronary artery; by graft, with cardiopulmonary bypass	CARDIAC SURGERY	78
33505	Repair of anomalous coronary artery; with construction of intrapulmonary artery tunnel (Takeuchi procedure)	CARDIAC SURGERY	78
33506	Repair of anomalous coronary artery; by translocation from pulmonary artery to aorta	CARDIAC SURGERY	78
33600	Closure of atrioventricular valve (mitral or tricuspid) by suture or patch	CARDIAC SURGERY	78
33602	Closure of semilunar valve (aortic or pulmonary) by suture or patch	CARDIAC SURGERY	78
33606	Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)	CARDIAC SURGERY	78
33608	Repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery	CARDIAC SURGERY	78
33610	Repair of complex cardiac anomalies (eg, single ventricle with subaortic obstruction) by surgical enlargement of ventricular septal defect	CARDIAC SURGERY	78
33611	Repair of double outlet right ventricle with intraventricular tunnel repair;	CARDIAC SURGERY	78
33612	Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction	CARDIAC SURGERY	78
33615	Repair of complex cardiac anomalies (eg, tricuspid atresia) by closure of atrial septal defect and anastomosis of atria or vena cava to pulmonary artery (simple Fontan procedure)	CARDIAC SURGERY	78
33617	Repair of complex cardiac anomalies (eg, single ventricle) by modified Fontan procedure	CARDIAC SURGERY	78
33619	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)	CARDIAC SURGERY	78
33645	Direct or patch closure, sinus venosus, with or without anomalous pulmonary venous drainage	CARDIAC SURGERY	78
33647	Repair of atrial septal defect and ventricular septal defect, with direct or patch closure	CARDIAC SURGERY	78
33660	Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair	CARDIAC SURGERY	78
33665	Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair	CARDIAC SURGERY	78
33670	Repair of complete atrioventricular canal, with or without prosthetic valve	CARDIAC SURGERY	78

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
33684	Closure of ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)	CARDIAC SURGERY	78
33688	Closure of ventricular septal defect, with or without patch; with removal of pulmonary artery band, with or without gusset	CARDIAC SURGERY	78
33690	Banding of pulmonary artery	CARDIAC SURGERY	78
33692	Complete repair tetralogy of Fallot without pulmonary atresia;	CARDIAC SURGERY	78
33694	Complete repair tetralogy of Fallot without pulmonary atresia; with transannular patch	CARDIAC SURGERY	78
33697	Complete repair tetralogy of Fallot with pulmonary atresia including construction of conduit from right ventricle to pulmonary artery and closure of ventricular septal defect	CARDIAC SURGERY	78
33702	Repair sinus of Valsalva fistula, with cardiopulmonary bypass;	CARDIAC SURGERY	78
33710	Repair sinus of Valsalva fistula, with cardiopulmonary bypass; with repair of ventricular septal defect	CARDIAC SURGERY	78
33720	Repair sinus of Valsalva aneurysm, with cardiopulmonary bypass	CARDIAC SURGERY	78
33722	Closure of aortico-left ventricular tunnel	CARDIAC SURGERY	78
33730	Complete repair of anomalous venous return (supracardiac, intracardiac, or infracardiac types)	CARDIAC SURGERY	78
33732	Repair of cor triatriatum or supravalvular mitral ring by resection of left atrial membrane	CARDIAC SURGERY	78
33735	Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)	CARDIAC SURGERY	78
33736	Atrial septectomy or septostomy; open heart with cardiopulmonary bypass	CARDIAC SURGERY	78
33737	Atrial septectomy or septostomy; open heart, with inflow occlusion	CARDIAC SURGERY	78
33750	Shunt; subclavian to pulmonary artery (Blalock-Taussig type operation)	CARDIAC SURGERY	78
33755	Shunt; ascending aorta to pulmonary artery (Waterston type operation)	CARDIAC SURGERY	78
33762	Shunt; descending aorta to pulmonary artery (Potts-Smith type operation)	CARDIAC SURGERY	78
33764	Shunt; central, with prosthetic graft	CARDIAC SURGERY	78
33766	Shunt; superior vena cava to pulmonary artery for flow to one lung (classical Glenn procedure)	CARDIAC SURGERY	78
33767	Shunt; superior vena cava to pulmonary artery for flow to both lungs (bidirectional Glenn procedure)	CARDIAC SURGERY	78
33770	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	CARDIAC SURGERY	78
33771	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect	CARDIAC SURGERY	78

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
33774	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass;	CARDIAC SURGERY	78
33775	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band	CARDIAC SURGERY	78
33776	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with closure of ventricular septal defect	CARDIAC SURGERY	78
33777	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction	CARDIAC SURGERY	33
33778	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type);	CARDIAC SURGERY	78
33779	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band	CARDIAC SURGERY	78
33780	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect	CARDIAC SURGERY	78
33781	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction	CARDIAC SURGERY	78
33786	Total repair, truncus arteriosus (Rastelli type operation)	CARDIAC SURGERY	78
33788	Reimplantation of an anomalous pulmonary artery	CARDIAC SURGERY	78
33800	Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)	THORACIC SURGERY	33
33802	Division of aberrant vessel (vascular ring);	CARDIAC SURGERY	78
33803	Division of aberrant vessel (vascular ring); with reanastomosis	CARDIAC SURGERY	78
33813	Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass	CARDIAC SURGERY	78
33814	Obliteration of aortopulmonary septal defect; with cardiopulmonary bypass	CARDIAC SURGERY	78
33820	Repair of patent ductus arteriosus; by ligation	CARDIAC SURGERY	78
33822	Repair of patent ductus arteriosus; by division, under 18 years	CARDIAC SURGERY	78
33824	Repair of patent ductus arteriosus; by division, 18 years and older	CARDIAC SURGERY	78
33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis	CARDIAC SURGERY	78
33845	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with graft	CARDIAC SURGERY	78

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
33851	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; repair using either left subclavian artery or prosthetic material as gusset for enlargement	CARDIAC SURGERY	78
33852	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass	CARDIAC SURGERY	78
33853	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; with cardiopulmonary bypass	CARDIAC SURGERY	78
33910	Pulmonary artery embolectomy; with cardiopulmonary bypass	CARDIAC SURGERY	78
33915	Pulmonary artery embolectomy; without cardiopulmonary bypass	CARDIAC SURGERY	78
33916	Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass	CARDIAC SURGERY	78
33917	Repair of pulmonary artery stenosis by reconstruction with patch or graft	CARDIAC SURGERY	78
33918	Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; without cardiopulmonary bypass	CARDIAC SURGERY	78
33919	Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; with cardiopulmonary bypass	CARDIAC SURGERY	78
33920	Repair of pulmonary atresia with ventricular septal defect, by construction or replacement of conduit from right or left ventricle to pulmonary artery	CARDIAC SURGERY	78
33922	Transection of pulmonary artery with cardiopulmonary bypass	CARDIAC SURGERY	78
33924	Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)	CARDIAC SURGERY	78
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy	CARDIAC SURGERY	78
33960	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours	THORACIC SURGERY	33
33961	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours (List separately in addition to code for primary procedure)	CARDIAC SURGERY	78
33976	Insertion of ventricular assist device; extracorporeal, biventricular	THORACIC SURGERY	33
33978	Removal of ventricular assist device; extracorporeal, biventricular	CARDIAC SURGERY	78
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	CARDIAC SURGERY	78
34051	Embolectomy or thrombectomy, with or without catheter; innominate, subclavian artery, by thoracic incision	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
34451	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision	VASCULAR SURGERY	77
34471	Thrombectomy, direct or with catheter; subclavian vein, by neck incision	GENERAL SURGERY	02
34501	Valvuloplasty, femoral vein	GENERAL SURGERY	02
34510	Venous valve transposition, any vein donor	GENERAL SURGERY	02
34530	Saphenopopliteal vein anastomosis	GENERAL SURGERY	02
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	VASCULAR SURGERY	77
34832	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis	VASCULAR SURGERY	77
34834	Open brachial artery exposure to assist in the deployment of infrarenal aortic or iliac endovascular prosthesis by arm incision, unilateral	VASCULAR SURGERY	77
35002	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, carotid, subclavian artery, by neck incision	GENERAL SURGERY	02
35005	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery	GENERAL SURGERY	02
35021	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision	CARDIAC SURGERY	78
35022	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, innominate, subclavian artery, by thoracic incision	CARDIAC SURGERY	78
35111	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery	GENERAL SURGERY	02
35112	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery	GENERAL SURGERY	02
35122	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery	GENERAL SURGERY	02
35152	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
35180	Repair, congenital arteriovenous fistula; head and neck	GENERAL SURGERY	02
35182	Repair, congenital arteriovenous fistula; thorax and abdomen	GENERAL SURGERY	02
35188	Repair, acquired or traumatic arteriovenous fistula; head and neck	GENERAL SURGERY	02
35189	Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen	GENERAL SURGERY	02
35246	Repair blood vessel with vein graft; intrathoracic, without bypass	CARDIAC SURGERY	78
35271	Repair blood vessel with graft other than vein; intrathoracic, with bypass	CARDIAC SURGERY	78
35276	Repair blood vessel with graft other than vein; intrathoracic, without bypass	CARDIAC SURGERY	78
35311	Thromboendarterectomy, with or without patch graft; subclavian, innominate, by thoracic incision	VASCULAR SURGERY	77
35363	Thromboendarterectomy, with or without patch graft; combined aortoiliofemoral	VASCULAR SURGERY	77
35480	Transluminal peripheral atherectomy, open; renal or other visceral artery	VASCULAR SURGERY	77
35481	Transluminal peripheral atherectomy, open; aortic	THORACIC SURGERY	33
35482	Transluminal peripheral atherectomy, open; iliac	GENERAL SURGERY	02
35484	Transluminal peripheral atherectomy, open; brachiocephalic trunk or branches, each vessel	GENERAL SURGERY	02
35485	Transluminal peripheral atherectomy, open; tibioperoneal trunk and branches	THORACIC SURGERY	33
35491	Transluminal peripheral atherectomy, percutaneous; aortic	CARDIOLOGY	06
35494	Transluminal peripheral atherectomy, percutaneous; brachiocephalic trunk or branches, each vessel	CARDIOLOGY	06
35507	Bypass graft, with vein; subclavian-carotid	VASCULAR SURGERY	77
35508	Bypass graft, with vein; carotid-vertebral	VASCULAR SURGERY	77
35511	Bypass graft, with vein; subclavian-subclavian	VASCULAR SURGERY	77
35512	Bypass graft, with vein; subclavian-brachial	VASCULAR SURGERY	77
35515	Bypass graft, with vein; subclavian-vertebral	VASCULAR SURGERY	77
35516	Bypass graft, with vein; subclavian-axillary	VASCULAR SURGERY	77
35518	Bypass graft, with vein; axillary-axillary	VASCULAR SURGERY	77
35521	Bypass graft, with vein; axillary-femoral	VASCULAR SURGERY	77
35526	Bypass graft, with vein; aortosubclavian or carotid	VASCULAR SURGERY	77
35533	Bypass graft, with vein; axillary-femoral-femoral	VASCULAR SURGERY	77
35536	Bypass graft, with vein; splenorenal	VASCULAR SURGERY	77
35541	Bypass graft, with vein; aortoiliac or bi-iliac	VASCULAR SURGERY	77
35548	Bypass graft, with vein; aortoiliofemoral, unilateral	VASCULAR SURGERY	77
35549	Bypass graft, with vein; aortoiliofemoral, bilateral	VASCULAR SURGERY	77
35551	Bypass graft, with vein; aortofemoral-popliteal	VASCULAR SURGERY	77
35563	Bypass graft, with vein; ilioiliac	VASCULAR SURGERY	77
35612	Bypass graft, with other than vein; subclavian-subclavian	VASCULAR SURGERY	77
35616	Bypass graft, with other than vein; subclavian-axillary	VASCULAR SURGERY	77

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
35636	Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis)	VASCULAR SURGERY	77
35642	Bypass graft, with other than vein; carotid-vertebral	VASCULAR SURGERY	77
35645	Bypass graft, with other than vein; subclavian-vertebral	VASCULAR SURGERY	77
35651	Bypass graft, with other than vein; aortofemoral-popliteal	VASCULAR SURGERY	77
35691	Transposition and/or reimplantation; vertebral to carotid artery	VASCULAR SURGERY	77
35693	Transposition and/or reimplantation; vertebral to subclavian artery	VASCULAR SURGERY	77
35694	Transposition and/or reimplantation; subclavian to carotid artery	VASCULAR SURGERY	77
35695	Transposition and/or reimplantation; carotid to subclavian artery	VASCULAR SURGERY	77
35905	Excision of infected graft; thorax	GENERAL SURGERY	02
36261	Revision of implanted intra-arterial infusion pump	GENERAL SURGERY	02
36400	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture; femoral or jugular vein	EMERGENCY MEDICINE	93
36405	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein	EMERGENCY MEDICINE	93
36420	Venipuncture, cutdown; under age 1 year	EMERGENCY MEDICINE	93
36440	Push transfusion, blood, 2 years or under	PEDIATRIC MEDICINE	37
36450	Exchange transfusion, blood; newborn	PEDIATRIC MEDICINE	37
36460	Transfusion, intrauterine, fetal	OB-GYN	16
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	GENERAL SURGERY	02
36469	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face	PEDIATRIC MEDICINE	37
36510	Catheterization of umbilical vein for diagnosis or therapy, newborn	HEMATOLOGY/ONCOLOGY	83
36660	Catheterization, umbilical artery, newborn, for diagnosis or therapy	PEDIATRIC MEDICINE	37
37145	Venous anastomosis, open; renoportal	GENERAL SURGERY	02
37160	Venous anastomosis, open; caval-mesenteric	GENERAL SURGERY	02
37180	Venous anastomosis, open; splenorenal, proximal	GENERAL SURGERY	02
37181	Venous anastomosis, open; splenorenal, distal (selective decompression of esophagogastric varices, any technique)	GENERAL SURGERY	02
37195	Thrombolysis, cerebral, by intravenous infusion	NEUROLOGY	13
37606	Ligation; internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp	NEUROSURGERY	14
37615	Ligation, major artery (eg, post-traumatic, rupture); neck	GENERAL SURGERY	2
37616	Ligation, major artery (eg, post-traumatic, rupture); chest	CARDIAC SURGERY	78
37660	Ligation of common iliac vein	GENERAL SURGERY	02
37788	Penile revascularization, artery, with or without vein graft	UROLOGY	34

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
37790	Penile venous occlusive procedure	UROLOGY	34
38101	Splenectomy; partial (separate procedure)	GENERAL SURGERY	02
38200	Injection procedure for splenoportography	DIAGNOSTIC RADIOLOGY	30
38242	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions	HEMATOLOGY/ONCOLOGY	83
38380	Suture and/or ligation of thoracic duct; cervical approach	OTOLARYNGOLOGY	04
38381	Suture and/or ligation of thoracic duct; thoracic approach	THORACIC SURGERY	33
38382	Suture and/or ligation of thoracic duct; abdominal approach	GENERAL SURGERY	02
38550	Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection	GENERAL SURGERY	02
38555	Excision of cystic hygroma, axillary or cervical; with deep neurovascular dissection	GENERAL SURGERY	02
38794	Cannulation, thoracic duct	DIAGNOSTIC RADIOLOGY	30
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	GENERAL SURGERY	02
39530	Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal	GENERAL SURGERY	02
39531	Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal, with dilation of stricture (with or without gastroplasty)	GENERAL SURGERY	02
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	GENERAL SURGERY	02
39545	Imbrication of diaphragm for eventration, transthoracic or transabdominal, paralytic or nonparalytic	THORACIC SURGERY	33
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	PLASTIC AND RECONSTUCTIVE SURGERY	24
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure	PLASTIC AND RECONSTUCTIVE SURGERY	24
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages	PLASTIC AND RECONSTUCTIVE SURGERY	24
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	PLASTIC AND RECONSTUCTIVE SURGERY	24
40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle	PLASTIC AND RECONSTUCTIVE SURGERY	24
40805	Removal of embedded foreign body, vestibule of mouth; complicated	ORAL SURGERY	19
40806	Incision of labial frenum (frenotomy)	ORAL SURGERY	19
40840	Vestibuloplasty; anterior	ORAL SURGERY	19
40842	Vestibuloplasty; posterior, unilateral	OTOLARYNGOLOGY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
40843	Vestibuloplasty; posterior, bilateral	OTOLARYNGOLOGY	04
40844	Vestibuloplasty; entire arch	OTOLARYNGOLOGY	04
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)	OTOLARYNGOLOGY	04
41005	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial	ORAL SURGERY	19
41006	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid	ORAL SURGERY	19
41007	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space	ORAL SURGERY	19
41010	Incision of lingual frenum (frenotomy)	OTOLARYNGOLOGY	04
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	ORAL SURGERY	19
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space	ORAL SURGERY	19
41115	Excision of lingual frenum (frenectomy)	OTOLARYNGOLOGY	04
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	OTOLARYNGOLOGY	04
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	OTOLARYNGOLOGY	04
41251	Repair of laceration 2.5 cm or less; posterior one-third of tongue	EMERGENCY MEDICINE	93
41500	Fixation of tongue, mechanical, other than suture (eg, K-wire)	OTOLARYNGOLOGY	04
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)	OTOLARYNGOLOGY	04
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	OTOLARYNGOLOGY	04
41820	Gingivectomy, excision gingiva, each quadrant	ORAL SURGERY	19
41821	Operculectomy, excision pericoronal tissues	ORAL SURGERY	19
41822	Excision of fibrous tuberosities, dentoalveolar structures	ORAL SURGERY	19
41823	Excision of osseous tuberosities, dentoalveolar structures	ORAL SURGERY	19
41850	Destruction of lesion (except excision), dentoalveolar structures	ORAL SURGERY	19
41870	Periodontal mucosal grafting	ORAL SURGERY	19
41872	Gingivoplasty, each quadrant (specify)	ORAL SURGERY	19
42000	Drainage of abscess of palate, uvula	OTOLARYNGOLOGY	04
42180	Repair, laceration of palate; up to 2 cm	OTOLARYNGOLOGY	04
42182	Repair, laceration of palate; over 2 cm or complex	OTOLARYNGOLOGY	04
42200	Palatoplasty for cleft palate, soft and/or hard palate only	PLASTIC AND RECONSTUCTIVE SURGERY	24
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	PLASTIC AND RECONSTUCTIVE SURGERY	24

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	PLASTIC AND RECONSTUCTIVE SURGERY	24
42215	Palatoplasty for cleft palate; major revision	PLASTIC AND RECONSTUCTIVE SURGERY	24
42220	Palatoplasty for cleft palate; secondary lengthening procedure	PLASTIC AND RECONSTUCTIVE SURGERY	24
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	PLASTIC AND RECONSTUCTIVE SURGERY	24
42226	Lengthening of palate, and pharyngeal flap	OTOLARYNGOLOGY	04
42227	Lengthening of palate, with island flap	OTOLARYNGOLOGY	04
42235	Repair of anterior palate, including vomer flap	OTOLARYNGOLOGY	04
42260	Repair of nasolabial fistula	PLASTIC AND RECONSTUCTIVE SURGERY	24
42281	Insertion of pin-retained palatal prosthesis	OTOLARYNGOLOGY	04
42320	Drainage of abscess; submaxillary, external	OTOLARYNGOLOGY	04
42325	Fistulization of sublingual salivary cyst (ranula);	OTOLARYNGOLOGY	04
42326	Fistulization of sublingual salivary cyst (ranula); with prosthesis	OTOLARYNGOLOGY	04
42340	Sialolithotomy; parotid, extraoral or complicated intraoral	OTOLARYNGOLOGY	04
42409	Marsupialization of sublingual salivary cyst (ranula)	OTOLARYNGOLOGY	04
42505	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated	OTOLARYNGOLOGY	04
42507	Parotid duct diversion, bilateral (Wilke type procedure);	OTOLARYNGOLOGY	04
42508	Parotid duct diversion, bilateral (Wilke type procedure); with excision of one submandibular gland	OTOLARYNGOLOGY	04
42509	Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands	OTOLARYNGOLOGY	04
42510	Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both submandibular (Wharton's) ducts	OTOLARYNGOLOGY	04
42600	Closure salivary fistula	OTOLARYNGOLOGY	04
42665	Ligation salivary duct, intraoral	OTOLARYNGOLOGY	04
42725	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach	OTOLARYNGOLOGY	04
42810	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues	OTOLARYNGOLOGY	04
42820	Tonsillectomy and adenoidectomy; under age 12	OTOLARYNGOLOGY	04
42825	Tonsillectomy, primary or secondary; under age 12	OTOLARYNGOLOGY	04
42830	Adenoidectomy, primary; under age 12	OTOLARYNGOLOGY	04
42835	Adenoidectomy, secondary; under age 12	OTOLARYNGOLOGY	04
42836	Adenoidectomy, secondary; age 12 or over	OTOLARYNGOLOGY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)	OTOLARYNGOLOGY	04
42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap	OTOLARYNGOLOGY	04
42860	Excision of tonsil tags	OTOLARYNGOLOGY	04
42900	Suture pharynx for wound or injury	OTOLARYNGOLOGY	04
42955	Pharyngostomy (fistulization of pharynx, external for feeding)	OTOLARYNGOLOGY	04
42961	Control oropharyngeal hemorrhage, primary or secondary (eg, post-tonsillectomy); complicated, requiring hospitalization	OTOLARYNGOLOGY	04
42971	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); complicated, requiring hospitalization	OTOLARYNGOLOGY	04
42972	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy); with secondary surgical intervention	OTOLARYNGOLOGY	04
43020	Esophagotomy, cervical approach, with removal of foreign body	GENERAL SURGERY	02
43045	Esophagotomy, thoracic approach, with removal of foreign body	THORACIC SURGERY	33
43100	Excision of lesion, esophagus, with primary repair; cervical approach	OTOLARYNGOLOGY	04
43101	Excision of lesion, esophagus, with primary repair; thoracic or abdominal approach	GENERAL SURGERY	02
43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)	GENERAL SURGERY	02
43113	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	THORACIC SURGERY	33
43116	Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction	THORACIC SURGERY	33
43118	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	GENERAL SURGERY	02
43121	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty	THORACIC SURGERY	33
43123	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	THORACIC SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
43124	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy	THORACIC SURGERY	33
43300	Esophagoplasty (plastic repair or reconstruction), cervical approach; without repair of tracheoesophageal fistula	OTOLARYNGOLOGY	04
43312	Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula	THORACIC SURGERY	33
43313	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula	THORACIC SURGERY	33
43314	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula	THORACIC SURGERY	33
43320	Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach	GENERAL SURGERY	02
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	GENERAL SURGERY	02
43331	Esophagomyotomy (Heller type); thoracic approach	THORACIC SURGERY	33
43340	Esophagojejunostomy (without total gastrectomy); abdominal approach	GENERAL SURGERY	02
43341	Esophagojejunostomy (without total gastrectomy); thoracic approach	GENERAL SURGERY	02
43350	Esophagostomy, fistulization of esophagus, external; abdominal approach	GENERAL SURGERY	02
43351	Esophagostomy, fistulization of esophagus, external; thoracic approach	THORACIC SURGERY	33
43352	Esophagostomy, fistulization of esophagus, external; cervical approach	THORACIC SURGERY	33
43360	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with stomach, with or without pyloroplasty	GENERAL SURGERY	02
43361	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula, or for previous esophageal exclusion; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	GENERAL SURGERY	02
43400	Ligation, direct, esophageal varices	GENERAL SURGERY	02
43401	Transection of esophagus with repair, for esophageal varices	GENERAL SURGERY	02
43405	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation	GENERAL SURGERY	02
43410	Suture of esophageal wound or injury; cervical approach	GENERAL SURGERY	02
43420	Closure of esophagostomy or fistula; cervical approach	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
43425	Closure of esophagostomy or fistula; transthoracic or transabdominal approach	GENERAL SURGERY	02
43460	Esophagogastric tamponade, with balloon (Sengstaaken type)	GASTROENTEROLOGY	10
43496	Free jejunum transfer with microvascular anastomosis	PLASTIC AND RECONSTUCTIVE SURGERY	24
43502	Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)	GENERAL SURGERY	02
43510	Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)	GENERAL SURGERY	02
43634	Gastrectomy, partial, distal; with formation of intestinal pouch	GENERAL SURGERY	02
43641	Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective)	GENERAL SURGERY	02
43651	Laparoscopy, surgical; transection of vagus nerves, truncal	GENERAL SURGERY	02
43652	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective	GENERAL SURGERY	02
43752	Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)	DIAGNOSTIC RADIOLOGY	30
43810	Gastroduodenostomy	GENERAL SURGERY	02
43831	Gastrostomy, open; neonatal, for feeding	GENERAL SURGERY	02
43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy	GENERAL SURGERY	02
43855	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy	GENERAL SURGERY	02
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	GENERAL SURGERY	02
44126	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering	GENERAL SURGERY	02
44127	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering	GENERAL SURGERY	02
44128	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	GENERAL SURGERY	02
44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy	GENERAL SURGERY	02
44203	Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)	GENERAL SURGERY	02
44211	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy	GENERAL SURGERY	02
44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy	GENERAL SURGERY	02
44239	Unlisted laparoscopy procedure, rectum	GENERAL SURGERY	02
44316	Continent ileostomy (Kock procedure) (separate procedure)	GENERAL SURGERY	02
44322	Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure)	GENERAL SURGERY	02
44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)	GASTROENTEROLOGY	10
44379	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)	GASTROENTEROLOGY	10
44390	Colonoscopy through stoma; with removal of foreign body	GASTROENTEROLOGY	10
44397	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)	GASTROENTEROLOGY	10
44680	Intestinal plication (separate procedure)	GENERAL SURGERY	02
44850	Suture of mesentery (separate procedure)	GENERAL SURGERY	02
45108	Anorectal myomectomy	GENERAL SURGERY	02
45113	Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy	GENERAL SURGERY	02
45114	Proctectomy, partial, with anastomosis; abdominal and transsacral approach	GENERAL SURGERY	02
45116	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)	GENERAL SURGERY	02
45120	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)	GENERAL SURGERY	02
45121	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
45126	Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof	GENERAL SURGERY	02
45135	Excision of rectal procidentia, with anastomosis; abdominal and perineal approach	GENERAL SURGERY	02
45136	Excision of ileoanal reservoir with ileostomy	COLORECTAL SURGERY	28
45150	Division of stricture of rectum	GENERAL SURGERY	02
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)	GENERAL SURGERY	02
45563	Exploration, repair, and presacral drainage for rectal injury; with colostomy	GENERAL SURGERY	02
45805	Closure of rectovesical fistula; with colostomy	GENERAL SURGERY	02
45820	Closure of rectourethral fistula;	GENERAL SURGERY	02
45825	Closure of rectourethral fistula; with colostomy	GENERAL SURGERY	02
46070	Incision, anal septum (infant)	GENERAL SURGERY	02
46210	Cryptectomy; single	GENERAL SURGERY	02
46211	Cryptectomy; multiple (separate procedure)	GENERAL SURGERY	02
46612	Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	GENERAL SURGERY	02
46705	Anoplasty, plastic operation for stricture; infant	GENERAL SURGERY	02
46715	Repair of low imperforate anus; with anoperineal fistula (cut-back procedure)	GENERAL SURGERY	02
46716	Repair of low imperforate anus; with transposition of anoperineal or anovestibular fistula	GENERAL SURGERY	02
46730	Repair of high imperforate anus without fistula; perineal or sacroperineal approach	GENERAL SURGERY	02
46735	Repair of high imperforate anus without fistula; combined transabdominal and sacroperineal approaches	GENERAL SURGERY	02
46740	Repair of high imperforate anus with rectourethral or rectovaginal fistula; perineal or sacroperineal approach	GENERAL SURGERY	02
46742	Repair of high imperforate anus with rectourethral or rectovaginal fistula; combined transabdominal and sacroperineal approaches	GENERAL SURGERY	02
46744	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach	GENERAL SURGERY	02
46746	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;	GENERAL SURGERY	02
46748	Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach; with vaginal lengthening by intestinal graft or pedicle flaps	GENERAL SURGERY	02
46751	Sphincteroplasty, anal, for incontinence or prolapse; child	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
46754	Removal of Thiersch wire or suture, anal canal	GENERAL SURGERY	02
46760	Sphincteroplasty, anal, for incontinence, adult; muscle transplant	COLORECTAL SURGERY	28
46762	Sphincteroplasty, anal, for incontinence, adult; implantation artificial sphincter	COLORECTAL SURGERY	28
46937	Cryosurgery of rectal tumor; benign	GENERAL SURGERY	02
46938	Cryosurgery of rectal tumor; malignant	GENERAL SURGERY	02
47015	Laparotomy, with aspiration and/or injection of hepatic parasitic (eg, amoebic or echinococcal) cyst(s) or abscess(es)	GENERAL SURGERY	02
47360	Management of liver hemorrhage; complex suture of liver wound or injury, with or without hepatic artery ligation	GENERAL SURGERY	02
47362	Management of liver hemorrhage; re-exploration of hepatic wound for removal of packing	GENERAL SURGERY	02
47371	Laparoscopy, surgical, ablation of one or more liver tumor(s); cryosurgical	GENERAL SURGERY	02
47381	Ablation, open, of one or more liver tumor(s); cryosurgical	GENERAL SURGERY	02
47400	Hepaticotomy or hepaticostomy with exploration, drainage, or removal of calculus	GENERAL SURGERY	02
47425	Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystotomy; with transduodenal sphincterotomy or sphincteroplasty	GENERAL SURGERY	02
47561	Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy	GENERAL SURGERY	02
47570	Laparoscopy, surgical; cholecystoenterostomy	GENERAL SURGERY	02
47700	Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography	GENERAL SURGERY	02
47701	Portoenterostomy (eg, Kasai procedure)	GENERAL SURGERY	02
47712	Excision of bile duct tumor, with or without primary repair of bile duct; intrahepatic	GENERAL SURGERY	02
47715	Excision of choledochal cyst	GENERAL SURGERY	02
47716	Anastomosis, choledochal cyst, without excision	GENERAL SURGERY	02
47740	Cholecystoenterostomy; Roux-en-Y	GENERAL SURGERY	02
47765	Anastomosis, of intrahepatic ducts and gastrointestinal tract	GENERAL SURGERY	02
47800	Reconstruction, plastic, of extrahepatic biliary ducts with end-to-end anastomosis	GENERAL SURGERY	02
47802	U-tube hepaticoenterostomy	GENERAL SURGERY	02
48001	Placement of drains, peripancreatic, for acute pancreatitis; with cholecystostomy, gastrostomy, and jejunostomy	GENERAL SURGERY	02
48020	Removal of pancreatic calculus	GENERAL SURGERY	02
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy	GENERAL SURGERY	02
48146	Pancreatectomy, distal, near-total with preservation of duodenum (Child-type procedure)	GENERAL SURGERY	02
48148	Excision of ampulla of Vater	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); without pancreatojejunostomy	GENERAL SURGERY	02
48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); without pancreatojejunostomy	GENERAL SURGERY	02
48155	Pancreatectomy, total	GENERAL SURGERY	02
48400	Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)	GENERAL SURGERY	02
48500	Marsupialization of pancreatic cyst	GENERAL SURGERY	02
48545	Pancreatorrhaphy for injury	GENERAL SURGERY	02
48547	Duodenal exclusion with gastrojejunostomy for pancreatic injury	GENERAL SURGERY	02
48550	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	GENERAL SURGERY	02
48556	Removal of transplanted pancreatic allograft	GENERAL SURGERY	02
49220	Staging laparotomy for Hodgkins disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominal nodes, abdominal node and/or bone marrow biopsies, ovarian repositioning)	GENERAL SURGERY	02
49428	Ligation of peritoneal-venous shunt	GENERAL SURGERY	02
49491	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible	GENERAL SURGERY	02
49492	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated	GENERAL SURGERY	02
49495	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy; reducible	GENERAL SURGERY	02
49496	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy; incarcerated or strangulated	GENERAL SURGERY	02
49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible	GENERAL SURGERY	02
49501	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; incarcerated or strangulated	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
49580	Repair umbilical hernia, under age 5 years; reducible	GENERAL SURGERY	02
49600	Repair of small omphalocele, with primary closure	GENERAL SURGERY	02
49605	Repair of large omphalocele or gastroschisis; with or without prosthesis	GENERAL SURGERY	02
49606	Repair of large omphalocele or gastroschisis; with removal of prosthesis, final reduction and closure, in operating room	GENERAL SURGERY	02
49610	Repair of omphalocele (Gross type operation); first stage	GENERAL SURGERY	02
49611	Repair of omphalocele (Gross type operation); second stage	GENERAL SURGERY	02
49906	Free omental flap with microvascular anastomosis	GENERAL SURGERY	02
50045	Nephrotomy, with exploration	UROLOGY	34
50060	Nephrolithotomy; removal of calculus	UROLOGY	34
50065	Nephrolithotomy; secondary surgical operation for calculus	UROLOGY	34
50070	Nephrolithotomy; complicated by congenital kidney abnormality	UROLOGY	34
50075	Nephrolithotomy; removal of large staghorn calculus filling renal pelvis and calyces (including anatrophic pyelolithotomy)	UROLOGY	34
50100	Transection or repositioning of aberrant renal vessels (separate procedure)	GENERAL SURGERY	02
50120	Pyelotomy; with exploration	UROLOGY	34
50125	Pyelotomy; with drainage, pyelostomy	UROLOGY	34
50135	Pyelotomy; complicated (eg, secondary operation, congenital kidney abnormality)	UROLOGY	34
50290	Excision of perinephric cyst	UROLOGY	34
50380	Renal autotransplantation, reimplantation of kidney	GENERAL SURGERY	02
50500	Nephrorrhaphy, suture of kidney wound or injury	GENERAL SURGERY	02
50520	Closure of nephrocutaneous or pyelocutaneous fistula	UROLOGY	34
50525	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; abdominal approach	UROLOGY	34
50526	Closure of nephrovisceral fistula (eg, renocolic), including visceral repair; thoracic approach	UROLOGY	34
50540	Symphysiotomy for horseshoe kidney with or without pyeloplasty and/or other plastic procedure, unilateral or bilateral (one operation)	UROLOGY	34
50544	Laparoscopy, surgical; pyeloplasty	UROLOGY	34
50555	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	UROLOGY	34
50557	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	UROLOGY	34

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
50562	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with resection of tumor	UROLOGY	34
50570	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	UROLOGY	34
50572	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	UROLOGY	34
50574	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	UROLOGY	34
50576	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	UROLOGY	34
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	UROLOGY	34
50610	Ureterolithotomy; upper one-third of ureter	UROLOGY	34
50620	Ureterolithotomy; middle one-third of ureter	UROLOGY	34
50660	Ureterectomy, total, ectopic ureter, combination abdominal, vaginal and/or perineal approach	UROLOGY	34
50686	Manometric studies through ureterostomy or indwelling ureteral catheter	UROLOGY	34
50722	Ureterolysis for ovarian vein syndrome	OB-GYN	16
50725	Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava	UROLOGY	34
50728	Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia	UROLOGY	34
50740	Ureteropyelostomy, anastomosis of ureter and renal pelvis	UROLOGY	34
50750	Ureterocalycostomy, anastomosis of ureter to renal calyx	UROLOGY	34
50770	Transureteroureterostomy, anastomosis of ureter to contralateral ureter	UROLOGY	34
50782	Ureteroneocystostomy; anastomosis of duplicated ureter to bladder	UROLOGY	34
50783	Ureteroneocystostomy; with extensive ureteral tailoring	UROLOGY	34
50810	Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
50815	Ureterocolon conduit, including intestine anastomosis	UROLOGY	34
50830	Urinary undiversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)	UROLOGY	34
50840	Replacement of all or part of ureter by intestine segment, including intestine anastomosis	UROLOGY	34
50845	Cutaneous appendico-vesicostomy	UROLOGY	34
50860	Ureterostomy, transplantation of ureter to skin	UROLOGY	34
50920	Closure of ureterocutaneous fistula	UROLOGY	34
50930	Closure of ureterovisceral fistula (including visceral repair)	UROLOGY	34
50940	Deligation of ureter	UROLOGY	34
50945	Laparoscopy, surgical; ureterolithotomy	UROLOGY	34
50947	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement	UROLOGY	34
50948	Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement	UROLOGY	34
50949	Unlisted laparoscopy procedure, ureter	UROLOGY	34
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	UROLOGY	34
50957	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	UROLOGY	34
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	UROLOGY	34
50972	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	UROLOGY	34
50974	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	UROLOGY	34
50976	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	UROLOGY	34
50980	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	UROLOGY	34
51030	Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesion	UROLOGY	34
51060	Transvesical ureterolithotomy	UROLOGY	34
51080	Drainage of perivesical or prevesical space abscess	UROLOGY	34

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
51500	Excision of urachal cyst or sinus, with or without umbilical hernia repair	UROLOGY	34
51520	Cystotomy; for simple excision of vesical neck (separate procedure)	UROLOGY	34
51535	Cystotomy for excision, incision, or repair of ureterocele	UROLOGY	34
51580	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations;	UROLOGY	34
51585	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	UROLOGY	34
51820	Cystourethroplasty with unilateral or bilateral ureteroneocystostomy	UROLOGY	34
51900	Closure of vesicovaginal fistula, abdominal approach	UROLOGY	34
51920	Closure of vesicouterine fistula;	UROLOGY	34
51925	Closure of vesicouterine fistula; with hysterectomy	OB-GYN	16
51940	Closure, exstrophy of bladder	UROLOGY	34
51980	Cutaneous vesicostomy	UROLOGY	34
52301	Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	UROLOGY	34
52343	Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	UROLOGY	34
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	UROLOGY	34
52402	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts	UROLOGY	34
52510	Transurethral balloon dilation of the prostatic urethra	UROLOGY	34
52700	Transurethral drainage of prostatic abscess	UROLOGY	34
53025	Meatotomy, cutting of meatus (separate procedure); infant	UROLOGY	34
53040	Drainage of deep periurethral abscess	UROLOGY	34
53060	Drainage of Skene's gland abscess or cyst	OB-GYN	16
53080	Drainage of perineal urinary extravasation; uncomplicated (separate procedure)	UROLOGY	34
53210	Urethrectomy, total, including cystostomy; female	UROLOGY	34
53235	Excision of urethral diverticulum (separate procedure); male	UROLOGY	34
53240	Marsupialization of urethral diverticulum, male or female	UROLOGY	34
53250	Excision of bulbourethral gland (Cowper's gland)	UROLOGY	34
53270	Excision or fulguration; Skene's glands	UROLOGY	34
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion	UROLOGY	34
53420	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage	UROLOGY	34
53425	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage	UROLOGY	34

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
53431	Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence (eg, Tenago, Leadbetter procedure)	UROLOGY	34
53442	Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)	UROLOGY	34
53448	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue	UROLOGY	34
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)	UROLOGY	34
53502	Urethrorrhaphy, suture of urethral wound or injury, female	UROLOGY	34
53505	Urethrorrhaphy, suture of urethral wound or injury; penile	UROLOGY	34
53510	Urethrorrhaphy, suture of urethral wound or injury; perineal	UROLOGY	34
53515	Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous	UROLOGY	34
53520	Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)	UROLOGY	34
54000	Slitting of prepuce, dorsal or lateral (separate procedure); newborn	UROLOGY	34
54110	Excision of penile plaque (Peyronie disease);	UROLOGY	34
54111	Excision of penile plaque (Peyronie disease); with graft to 5 cm in length	UROLOGY	34
54112	Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length	UROLOGY	34
54115	Removal foreign body from deep penile tissue (eg, plastic implant)	UROLOGY	34
54130	Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy	UROLOGY	34
54135	Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	UROLOGY	34
54150	Circumcision, using clamp or other device; newborn	UROLOGY	34
54160	Circumcision, surgical excision other than clamp, device or dorsal slit; newborn	UROLOGY	34
54164	Frenulotomy of penis	UROLOGY	34
54205	Injection procedure for Peyronie disease; with surgical exposure of plaque	UROLOGY	34
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra	UROLOGY	34
54304	Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps	UROLOGY	34
54308	Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm	UROLOGY	34
54312	Urethroplasty for second stage hypospadias repair (including urinary diversion); greater than 3 cm	UROLOGY	34

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
54316	Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia	UROLOGY	34
54318	Urethroplasty for third stage hypospadias repair to release penis from scrotum (eg, third stage Cecil repair)	UROLOGY	34
54322	One stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap)	UROLOGY	34
54324	One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)	UROLOGY	34
54326	One stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps and mobilization of urethra	UROLOGY	34
54328	One stage distal hypospadias repair (with or without chordee or circumcision); with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap	UROLOGY	34
54332	One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	UROLOGY	34
54336	One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap	UROLOGY	34
54340	Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple	UROLOGY	34
54344	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft	UROLOGY	34
54348	Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)	UROLOGY	34
54352	Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts	UROLOGY	34
54380	Plastic operation on penis for epispadias distal to external sphincter;	UROLOGY	34
54385	Plastic operation on penis for epispadias distal to external sphincter; with incontinence	UROLOGY	34
54390	Plastic operation on penis for epispadias distal to external sphincter; with exstrophy of bladder	UROLOGY	34

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	UROLOGY	34
54420	Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral	UROLOGY	34
54430	Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral	UROLOGY	34
54435	Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism	UROLOGY	34
54440	Plastic operation of penis for injury	UROLOGY	34
54500	Biopsy of testis, needle (separate procedure)	UROLOGY	34
54535	Orchiectomy, radical, for tumor; with abdominal exploration	UROLOGY	34
54550	Exploration for undescended testis (inguinal or scrotal area)	UROLOGY	34
54560	Exploration for undescended testis with abdominal exploration	UROLOGY	34
54600	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis	UROLOGY	34
54620	Fixation of contralateral testis (separate procedure)	UROLOGY	34
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)	UROLOGY	34
54660	Insertion of testicular prosthesis (separate procedure)	UROLOGY	34
54670	Suture or repair of testicular injury	UROLOGY	34
54680	Transplantation of testis(es) to thigh (because of scrotal destruction)	UROLOGY	34
54690	Laparoscopy, surgical; orchiectomy	UROLOGY	34
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal testis	UROLOGY	34
54699	Unlisted laparoscopy procedure, testis	UROLOGY	34
54800	Biopsy of epididymis, needle	UROLOGY	34
54820	Exploration of epididymis, with or without biopsy	UROLOGY	34
54861	Epididymectomy; bilateral	UROLOGY	34
54900	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral	UROLOGY	34
54901	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral	UROLOGY	34
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)	UROLOGY	34
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	UROLOGY	34
55400	Vasovasostomy, vasovasorrhaphy	UROLOGY	34
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)	UROLOGY	34
55535	Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach	UROLOGY	34
55550	Laparoscopy, surgical, with ligation of spermatic veins for varicocele	UROLOGY	34

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
55605	Vesiculotomy; complicated	UROLOGY	34
55650	Vesiculectomy, any approach	UROLOGY	34
55680	Excision of Mullerian duct cyst	UROLOGY	34
55725	Prostatotomy, external drainage of prostatic abscess, any approach; complicated	UROLOGY	34
55801	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	UROLOGY	34
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	UROLOGY	34
55862	Exposure of prostate, any approach, for insertion of radioactive substance; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	UROLOGY	34
55865	Exposure of prostate, any approach, for insertion of radioactive substance; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	UROLOGY	34
55870	Electroejaculation	UROLOGY	34
56634	Vulvectomy, radical, complete; with unilateral inguinofemoral lymphadenectomy	GYNECOLOGY/ONCOLOGY	98
56640	Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	GYNECOLOGY/ONCOLOGY	98
56700	Partial hymenectomy or revision of hymenal ring	OB-GYN	16
56720	Hymenotomy, simple incision	OB-GYN	16
56805	Clitoroplasty for intersex state	OB-GYN	16
57000	Colpotomy; with exploration	OB-GYN	16
57010	Colpotomy; with drainage of pelvic abscess	OB-GYN	16
57022	Incision and drainage of vaginal hematoma; obstetrical/postpartum	OB-GYN	16
57023	Incision and drainage of vaginal hematoma; non-obstetrical (eg, post-trauma, spontaneous bleeding)	OB-GYN	16
57109	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	GYNECOLOGY/ONCOLOGY	16
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)	GYNECOLOGY/ONCOLOGY	16
57112	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)	GYNECOLOGY/ONCOLOGY	98
57130	Excision of vaginal septum	OB-GYN	16
57230	Plastic repair of urethrocele	OB-GYN	16
57291	Construction of artificial vagina; without graft	OB-GYN	16
57292	Construction of artificial vagina; with graft	OB-GYN	16
57307	Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy	GENERAL SURGERY	02

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
57308	Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication	OB-GYN	16
57310	Closure of urethrovaginal fistula;	UROLOGY	34
57311	Closure of urethrovaginal fistula; with bulbocavernosus transplant	UROLOGY	34
57330	Closure of vesicovaginal fistula; transvesical and vaginal approach	UROLOGY	34
57335	Vaginoplasty for intersex state	OB-GYN	16
57531	Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)	OB-GYN	16
57540	Excision of cervical stump, abdominal approach;	OB-GYN	16
57545	Excision of cervical stump, abdominal approach; with pelvic floor repair	OB-GYN	16
57550	Excision of cervical stump, vaginal approach;	OB-GYN	16
57555	Excision of cervical stump, vaginal approach; with anterior and/or posterior repair	OB-GYN	16
57700	Cerclage of uterine cervix, nonobstetrical	OB-GYN	16
57720	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach	OB-GYN	16
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	OB-GYN	16
58285	Vaginal hysterectomy, radical (Schauta type operation)	GYNECOLOGY/ONCOLOGY	98
58291	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	OB-GYN	16
58292	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s), with repair of enterocele	OB-GYN	16
58293	Vaginal hysterectomy, for uterus greater than 250 grams; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	OB-GYN	16
58294	Vaginal hysterectomy, for uterus greater than 250 grams; with repair of enterocele	OB-GYN	16
58300	Insertion of intrauterine device (IUD)	OB-GYN	16
58321	Artificial insemination; intra-cervical	OB-GYN	16
58322	Artificial insemination; intra-uterine	OB-GYN	16
58323	Sperm washing for artificial insemination	OB-GYN	16
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography	OB-GYN	16
58346	Insertion of Heyman capsules for clinical brachytherapy	GYNECOLOGY/ONCOLOGY	98
58350	Chromotubation of oviduct, including materials	OB-GYN	16

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
58410	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with presacral sympathectomy	OB-GYN	16
58520	Hysterorrhaphy, repair of ruptured uterus (nonobstetrical)	OB-GYN	16
58540	Hysteroplasty, repair of uterine anomaly (Strassman type)	OB-GYN	16
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas	OB-GYN	16
58546	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams	OB-GYN	16
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;	OB-GYN	16
58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	OB-GYN	16
58562	Hysteroscopy, surgical; with removal of impacted foreign body	OB-GYN	16
58579	Unlisted hysteroscopy procedure, uterus	OB-GYN	16
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	OB-GYN	16
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	OB-GYN	16
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	OB-GYN	16
58672	Laparoscopy, surgical; with fimbrioplasty	OB-GYN	16
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)	OB-GYN	16
58679	Unlisted laparoscopy procedure, oviduct, ovary	OB-GYN	16
58750	Tubotubal anastomosis	OB-GYN	16
58752	Tubouterine implantation	OB-GYN	16
58760	Fimbrioplasty	OB-GYN	16
58770	Salpingostomy (salpingoneostomy)	OB-GYN	16
58800	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach	OB-GYN	16
58820	Drainage of ovarian abscess; vaginal approach, open	OB-GYN	16
58822	Drainage of ovarian abscess; abdominal approach	OB-GYN	16
58825	Transposition, ovary(s)	OB-GYN	16
58900	Biopsy of ovary, unilateral or bilateral (separate procedure)	OB-GYN	16
58920	Wedge resection or bisection of ovary, unilateral or bilateral	OB-GYN	16
58970	Follicle puncture for oocyte retrieval, any method	OB-GYN	16
58974	Embryo transfer, intrauterine	OB-GYN	16
58976	Gamete, zygote, or embryo intrafallopian transfer, any method	OB-GYN	16

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	OB-GYN	16
59012	Cordocentesis (intrauterine), any method	OB-GYN	16
59015	Chorionic villus sampling, any method	OB-GYN	16
59020	Fetal contraction stress test	OB-GYN	16
59030	Fetal scalp blood sampling	OB-GYN	16
59050	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation	OB-GYN	16
59070	Transabdominal amnioinfusion, including ultrasound guidance	OB-GYN	16
59072	Fetal umbilical cord occlusion, including ultrasound guidance	OB-GYN	16
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	OB-GYN	16
59076	Fetal shunt placement, including ultrasound guidance	OB-GYN	16
59100	Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)	OB-GYN	16
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	OB-GYN	16
59121	Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy	OB-GYN	16
59130	Surgical treatment of ectopic pregnancy; abdominal pregnancy	OB-GYN	16
59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy	OB-GYN	16
59136	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus	OB-GYN	16
59140	Surgical treatment of ectopic pregnancy; cervical, with evacuation	OB-GYN	16
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	OB-GYN	16
59151	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	OB-GYN	16
59160	Curettage, postpartum	OB-GYN	16
59300	Episiotomy or vaginal repair, by other than attending physician	OB-GYN	16
59320	Cerclage of cervix, during pregnancy; vaginal	OB-GYN	16
59325	Cerclage of cervix, during pregnancy; abdominal	OB-GYN	16
59350	Hysterorrhaphy of ruptured uterus	OB-GYN	16
59412	External cephalic version, with or without tocolysis	OB-GYN	16
59414	Delivery of placenta (separate procedure)	OB-GYN	16
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)	OB-GYN	16

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	OB-GYN	16
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	OB-GYN	16
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	OB-GYN	16
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	OB-GYN	16
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	OB-GYN	16
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	OB-GYN	16
59821	Treatment of missed abortion, completed surgically; second trimester	OB-GYN	16
59830	Treatment of septic abortion, completed surgically	OB-GYN	16
59840	Induced abortion, by dilation and curettage	OB-GYN	16
59841	Induced abortion, by dilation and evacuation	OB-GYN	16
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;	OB-GYN	16
59851	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	OB-GYN	16
59852	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)	OB-GYN	16
59855	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;	OB-GYN	16
59856	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	OB-GYN	16

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
59857	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)	OB-GYN	16
59866	Multifetal pregnancy reduction(s) (MPR)	OB-GYN	16
59870	Uterine evacuation and curettage for hydatidiform mole	OB-GYN	16
59871	Removal of cerclage suture under anesthesia (other than local)	OB-GYN	16
60000	Incision and drainage of thyroglossal duct cyst, infected	OTOLARYNGOLOGY	04
60281	Excision of thyroglossal duct cyst or sinus; recurrent	OTOLARYNGOLOGY	04
60605	Excision of carotid body tumor; with excision of carotid artery	VASCULAR SURGERY	77
61000	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial	NEUROSURGERY	14
61001	Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; subsequent taps	NEUROSURGERY	14
61120	Burr hole(s) for ventricular puncture (including injection of gas, contrast media, dye, or radioactive material)	NEUROSURGERY	14
61150	Burr hole(s) or trephine; with drainage of brain abscess or cyst	NEUROSURGERY	14
61151	Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cyst	NEUROSURGERY	14
61250	Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery	NEUROSURGERY	14
61253	Burr hole(s) or trephine, infratentorial, unilateral or bilateral	NEUROSURGERY	14
61305	Craniectomy or craniotomy, exploratory; infratentorial (posterior fossa)	NEUROSURGERY	14
61316	Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure)	NEUROSURGERY	14
61321	Craniectomy or craniotomy, drainage of intracranial abscess; infratentorial	NEUROSURGERY	14
61322	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy	NEUROSURGERY	14
61323	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; with lobectomy	NEUROSURGERY	14
61330	Decompression of orbit only, transcranial approach	NEUROSURGERY	14
61332	Exploration of orbit (transcranial approach); with biopsy	NEUROSURGERY	14
61333	Exploration of orbit (transcranial approach); with removal of lesion	NEUROSURGERY	14

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
61334	Exploration of orbit (transcranial approach); with removal of foreign body	NEUROSURGERY	14
61340	Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)	NEUROSURGERY	14
61345	Other cranial decompression, posterior fossa	NEUROSURGERY	14
61440	Craniotomy for section of tentorium cerebelli (separate procedure)	NEUROSURGERY	14
61450	Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion	NEUROSURGERY	14
61460	Craniectomy, suboccipital; for section of one or more cranial nerves	NEUROSURGERY	14
61470	Craniectomy, suboccipital; for medullary tractotomy	NEUROSURGERY	14
61480	Craniectomy, suboccipital; for mesencephalic tractotomy or pedunculotomy	NEUROSURGERY	14
61490	Craniotomy for lobotomy, including cingulotomy	NEUROSURGERY	14
61521	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull	NEUROSURGERY	14
61522	Craniectomy, infratentorial or posterior fossa; for excision of brain abscess	NEUROSURGERY	14
61524	Craniectomy, infratentorial or posterior fossa; for excision or fenestration of cyst	NEUROSURGERY	14
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;	NEUROSURGERY	14
61530	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy	NEUROSURGERY	14
61531	Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring	NEUROSURGERY	14
61534	Craniotomy with elevation of bone flap; for excision of epileptogenic focus without electrocorticography during surgery	NEUROSURGERY	14
61535	Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)	NEUROSURGERY	14
61536	Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)	NEUROSURGERY	14
61539	Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery	NEUROSURGERY	14
61541	Craniotomy with elevation of bone flap; for transection of corpus callosum	NEUROSURGERY	14
61542	Craniotomy with elevation of bone flap; for total hemispherectomy	NEUROSURGERY	14
61543	Craniotomy with elevation of bone flap; for partial or subtotal (functional) hemispherectomy	NEUROSURGERY	14

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
61544	Craniotomy with elevation of bone flap; for excision or coagulation of choroid plexus	NEUROSURGERY	14
61545	Craniotomy with elevation of bone flap; for excision of craniopharyngioma	NEUROSURGERY	14
61546	Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach	NEUROSURGERY	14
61550	Craniectomy for craniosynostosis; single cranial suture	NEUROSURGERY	14
61552	Craniectomy for craniosynostosis; multiple cranial sutures	NEUROSURGERY	14
61556	Craniotomy for craniosynostosis; frontal or parietal bone flap	NEUROSURGERY	14
61557	Craniotomy for craniosynostosis; bifrontal bone flap	NEUROSURGERY	14
61558	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts	NEUROSURGERY	14
61559	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); recontouring with multiple osteotomies and bone autografts (eg, barrel-stave procedure) (includes obtaining grafts)	NEUROSURGERY	14
61563	Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); without optic nerve decompression	NEUROSURGERY	14
61564	Excision, intra and extracranial, benign tumor of cranial bone (eg, fibrous dysplasia); with optic nerve decompression	NEUROSURGERY	14
61570	Craniectomy or craniotomy; with excision of foreign body from brain	NEUROSURGERY	14
61571	Craniectomy or craniotomy; with treatment of penetrating wound of brain	NEUROSURGERY	14
61575	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;	NEUROSURGERY	14
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)	NEUROSURGERY	14
61581	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy	OTOLARYNGOLOGY	04
61582	Craniofacial approach to anterior cranial fossa; extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa	NEUROSURGERY	14
61585	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); with orbital exenteration	NEUROSURGERY	14
61586	Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft	NEUROSURGERY	14

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
61591	Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery	OTOLARYNGOLOGY	04
61596	Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery	OTOLARYNGOLOGY	04
61598	Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	NEUROSURGERY	14
61606	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; intradural, including dural repair, with or without graft	NEUROSURGERY	14
61607	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural	NEUROSURGERY	14
61609	Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)	NEUROSURGERY	14
61610	Transection or ligation, carotid artery in cavernous sinus; with repair by anastomosis or graft (List separately in addition to code for primary procedure)	NEUROSURGERY	14
61611	Transection or ligation, carotid artery in petrous canal; without repair (List separately in addition to code for primary procedure)	NEUROSURGERY	14
61612	Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft (List separately in addition to code for primary procedure)	NEUROSURGERY	14
61613	Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus	NEUROSURGERY	14
61615	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; extradural	NEUROSURGERY	14
61619	Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)	NEUROSURGERY	14
61680	Surgery of intracranial arteriovenous malformation; supratentorial, simple	NEUROSURGERY	14

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
61684	Surgery of intracranial arteriovenous malformation; infratentorial, simple	NEUROSURGERY	14
61686	Surgery of intracranial arteriovenous malformation; infratentorial, complex	NEUROSURGERY	14
61690	Surgery of intracranial arteriovenous malformation; dural, simple	NEUROSURGERY	14
61692	Surgery of intracranial arteriovenous malformation; dural, complex	NEUROSURGERY	14
61698	Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation	NEUROSURGERY	14
61702	Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation	NEUROSURGERY	14
61703	Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)	NEUROSURGERY	14
61705	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery	NEUROSURGERY	14
61708	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial electrothrombosis	NEUROSURGERY	14
61711	Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries	NEUROSURGERY	14
61735	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus	NEUROSURGERY	13
61760	Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring	NEUROSURGERY	14
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	NEUROSURGERY	14
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	NEUROSURGERY	14
61870	Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical	NEUROSURGERY	14
61875	Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical	NEUROSURGERY	14
62000	Elevation of depressed skull fracture; simple, extradural	NEUROSURGERY	14
62005	Elevation of depressed skull fracture; compound or comminuted, extradural	NEUROSURGERY	14
62010	Elevation of depressed skull fracture; with repair of dura and/or debridement of brain	NEUROSURGERY	14
62115	Reduction of craniomegalic skull (eg, treated hydrocephalus); not requiring bone grafts or cranioplasty	NEUROSURGERY	14
62116	Reduction of craniomegalic skull (eg, treated hydrocephalus); with simple cranioplasty	NEUROSURGERY	14
62117	Reduction of craniomegalic skull (eg, treated hydrocephalus); requiring craniotomy and reconstruction with or without bone graft (includes obtaining grafts)	NEUROSURGERY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
62120	Repair of encephalocele, skull vault, including cranioplasty	NEUROSURGERY	14
62121	Craniotomy for repair of encephalocele, skull base	NEUROSURGERY	14
62146	Cranioplasty with autograft (includes obtaining bone grafts); up to 5 cm diameter	NEUROSURGERY	14
62147	Cranioplasty with autograft (includes obtaining bone grafts); larger than 5 cm diameter	NEUROSURGERY	14
62148	Incision and retrieval of subcutaneous cranial bone graft for cranioplasty (List separately in addition to code for primary procedure)	NEUROSURGERY	14
62161	Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)	NEUROSURGERY	14
62162	Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage	NEUROSURGERY	14
62163	Neuroendoscopy, intracranial; with retrieval of foreign body	NEUROSURGERY	14
62164	Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage	NEUROSURGERY	14
62165	Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach	NEUROSURGERY	14
62180	Ventriculocisternostomy (Torkildsen type operation)	NEUROSURGERY	14
62190	Creation of shunt; subarachnoid/subdural-atrial, -jugular, -auricular	NEUROSURGERY	14
62194	Replacement or irrigation, subarachnoid/subdural catheter	NEUROSURGERY	14
62200	Ventriculocisternostomy, third ventricle;	NEUROSURGERY	14
62201	Ventriculocisternostomy, third ventricle; stereotactic, neuroendoscopic method	NEUROSURGERY	14
62292	Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	ANESTHESIOLOGY	05
62294	Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal	NEUROSURGERY	14
63066	Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic; each additional segment (List separately in addition to code for primary procedure)	NEUROSURGERY	14
63170	Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumbar	NEUROSURGERY	14
63173	Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space	NEUROSURGERY	14
63180	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; one or two segments	NEUROSURGERY	14

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
63182	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than two segments	NEUROSURGERY	14
63185	Laminectomy with rhizotomy; one or two segments	NEUROSURGERY	14
63190	Laminectomy with rhizotomy; more than two segments	NEUROSURGERY	14
63191	Laminectomy with section of spinal accessory nerve	NEUROSURGERY	14
63194	Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; cervical	NEUROSURGERY	14
63195	Laminectomy with cordotomy, with section of one spinothalamic tract, one stage; thoracic	NEUROSURGERY	14
63196	Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; cervical	NEUROSURGERY	14
63197	Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage; thoracic	NEUROSURGERY	14
63198	Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days; cervical	NEUROSURGERY	14
63199	Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days; thoracic	NEUROSURGERY	14
63200	Laminectomy, with release of tethered spinal cord, lumbar	NEUROSURGERY	14
63250	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical	NEUROSURGERY	14
63251	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic	NEUROSURGERY	14
63252	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar	NEUROSURGERY	14
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	NEUROSURGERY	14
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical	NEUROSURGERY	14
63273	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral	NEUROSURGERY	14
63278	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral	NEUROSURGERY	14
63283	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, sacral	NEUROSURGERY	14
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical	NEUROSURGERY	14
63286	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic	NEUROSURGERY	14
63287	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar	NEUROSURGERY	14
63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level	NEUROSURGERY	14

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
63300	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical	NEUROSURGERY	14
63301	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach	NEUROSURGERY	14
63302	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach	NEUROSURGERY	14
63303	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach	NEUROSURGERY	14
63304	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical	NEUROSURGERY	14
63305	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach	NEUROSURGERY	14
63306	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach	NEUROSURGERY	14
63307	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach	NEUROSURGERY	14
63308	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment)	NEUROSURGERY	14
63610	Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery	NEUROSURGERY	14
63615	Stereotactic biopsy, aspiration, or excision of lesion, spinal cord	NEUROSURGERY	14
63700	Repair of meningocele; less than 5 cm diameter	NEUROSURGERY	14
63702	Repair of meningocele; larger than 5 cm diameter	NEUROSURGERY	14
63704	Repair of myelomeningocele; less than 5 cm diameter	NEUROSURGERY	14
63706	Repair of myelomeningocele; larger than 5 cm diameter	NEUROSURGERY	14
63746	Removal of entire lumbosubarachnoid shunt system without replacement	NEUROSURGERY	14
64410	Injection, anesthetic agent; phrenic nerve	ANESTHESIOLOGY	05
64508	Injection, anesthetic agent; carotid sinus (separate procedure)	ANESTHESIOLOGY	05
64553	Percutaneous implantation of neurostimulator electrodes; cranial nerve	NEUROSURGERY	14

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
64560	Percutaneous implantation of neurostimulator electrodes; autonomic nerve	NEUROSURGERY	14
64577	Incision for implantation of neurostimulator electrodes; autonomic nerve	NEUROSURGERY	14
64580	Incision for implantation of neurostimulator electrodes; neuromuscular	NEUROSURGERY	14
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	NEUROSURGERY	14
64732	Transection or avulsion of; supraorbital nerve	NEUROSURGERY	14
64734	Transection or avulsion of; infraorbital nerve	NEUROSURGERY	14
64736	Transection or avulsion of; mental nerve	ORAL SURGERY	19
64738	Transection or avulsion of; inferior alveolar nerve by osteotomy	MAXILLOFACIAL SURGERY	85
64740	Transection or avulsion of; lingual nerve	MAXILLOFACIAL SURGERY	85
64742	Transection or avulsion of; facial nerve, differential or complete	OPHTHALMOLOGY	18
64746	Transection or avulsion of; phrenic nerve	THORACIC SURGERY	33
64752	Transection or avulsion of; vagus nerve (vagotomy), transthoracic	GENERAL SURGERY	02
64755	Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)	GENERAL SURGERY	02
64760	Transection or avulsion of; vagus nerve (vagotomy), abdominal	GENERAL SURGERY	02
64761	Transection or avulsion of; pudendal nerve	OB-GYN	16
64763	Transection or avulsion of obturator nerve, extrapelvic, with or without adductor tenotomy	PLASTIC AND RECONSTUCTIVE SURGERY	24
64766	Transection or avulsion of obturator nerve, intrapelvic, with or without adductor tenotomy	OB-GYN	16
64771	Transection or avulsion of other cranial nerve, extradural	NEUROSURGERY	14
64778	Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)	ORTHOPEDIC SURGERY	20
64783	Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)	ORTHOPEDIC SURGERY	20
64786	Excision of neuroma; sciatic nerve	PLASTIC AND RECONSTUCTIVE SURGERY	24
64802	Sympathectomy, cervical	NEUROSURGERY	14
64804	Sympathectomy, cervicothoracic	NEUROSURGERY	14
64809	Sympathectomy, thoracolumbar	NEUROSURGERY	14
64821	Sympathectomy; radial artery	ORTHOPEDIC SURGERY	20
64822	Sympathectomy; ulnar artery	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
64823	Sympathectomy; superficial palmar arch	ORTHOPEDIC SURGERY	20
64835	Suture of one nerve, hand or foot; median motor thenar	ORTHOPEDIC SURGERY	20
64836	Suture of one nerve, hand or foot; ulnar motor	ORTHOPEDIC SURGERY	24
64837	Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure)	ORTHOPEDIC SURGERY	24
64840	Suture of posterior tibial nerve	ORTHOPEDIC SURGERY	24
64858	Suture of sciatic nerve	ORTHOPEDIC SURGERY	20
64859	Suture of each additional major peripheral nerve (List separately in addition to code for primary procedure)	ORTHOPEDIC SURGERY	20
64861	Suture of; brachial plexus	NEUROSURGERY	14
64862	Suture of; lumbar plexus	NEUROSURGERY	14
64865	Suture of facial nerve; infratemporal, with or without grafting	OTOLARYNGOLOGY	04
64866	Anastomosis; facial-spinal accessory	PLASTIC AND RECONSTUCTIVE SURGERY	24
64868	Anastomosis; facial-hypoglossal	OTOLARYNGOLOGY	04
64870	Anastomosis; facial-phrenic	OTOLARYNGOLOGY	04
64872	Suture of nerve; requiring secondary or delayed suture (List separately in addition to code for primary neurorrhaphy)	ORTHOPEDIC SURGERY	20
64874	Suture of nerve; requiring extensive mobilization, or transposition of nerve (List separately in addition to code for nerve suture)	ORTHOPEDIC SURGERY	20
64876	Suture of nerve; requiring shortening of bone of extremity (List separately in addition to code for nerve suture)	ORTHOPEDIC SURGERY	20
64885	Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length	OTOLARYNGOLOGY	04
64886	Nerve graft (includes obtaining graft), head or neck; more than 4 cm length	OTOLARYNGOLOGY	04
64890	Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length	ORTHOPEDIC SURGERY	20
64891	Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length	ORTHOPEDIC SURGERY	20
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length	ORTHOPEDIC SURGERY	20
64893	Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length	ORTHOPEDIC SURGERY	20
64895	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length	ORTHOPEDIC SURGERY	20
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length	ORTHOPEDIC SURGERY	20

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
64897	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length	ORTHOPEDIC SURGERY	20
64898	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length	ORTHOPEDIC SURGERY	20
64901	Nerve graft, each additional nerve; single strand (List separately in addition to code for primary procedure)	ORTHOPEDIC SURGERY	20
64902	Nerve graft, each additional nerve; multiple strands (cable) (List separately in addition to code for primary procedure)	ORTHOPEDIC SURGERY	20
64905	Nerve pedicle transfer; first stage	PLASTIC AND RECONSTUCTIVE SURGERY	24
64907	Nerve pedicle transfer; second stage	PLASTIC AND RECONSTUCTIVE SURGERY	24
65110	Exenteration of orbit (does not include skin graft), removal of orbital contents; only	OPHTHALMOLOGY	18
65112	Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone	OPHTHALMOLOGY	18
65114	Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap	OPHTHALMOLOGY	18
65125	Modification of ocular implant with placement or replacement of pegs (eg, drilling receptacle for prosthesis appendage) (separate procedure)	OPHTHALMOLOGY	18
65130	Insertion of ocular implant secondary; after evisceration, in scleral shell	OPHTHALMOLOGY	18
65135	Insertion of ocular implant secondary; after enucleation, muscles not attached to implant	OPHTHALMOLOGY	18
65140	Insertion of ocular implant secondary; after enucleation, muscles attached to implant	OPHTHALMOLOGY	18
65150	Reinsertion of ocular implant; with or without conjunctival graft	OPHTHALMOLOGY	18
65155	Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant	OPHTHALMOLOGY	18
65260	Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route	OPHTHALMOLOGY	18
65272	Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization	OPHTHALMOLOGY	18
65273	Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization	OPHTHALMOLOGY	18
65290	Repair of wound, extraocular muscle, tendon and/or Tenon's capsule	OPHTHALMOLOGY	18
65760	Keratomileusis	OPHTHALMOLOGY	18
65765	Keratophakia	OPHTHALMOLOGY	18
65767	Epikeratoplasty	OPHTHALMOLOGY	18

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
65771	Radial keratotomy	OPHTHALMOLOGY	18
65780	Ocular surface reconstruction; amniotic membrane transplantation	OPHTHALMOLOGY	18
65781	Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor)	OPHTHALMOLOGY	18
65782	Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)	OPHTHALMOLOGY	18
65820	Goniotomy	OPHTHALMOLOGY	18
66155	Fistulization of sclera for glaucoma; thermocauterization with iridectomy	OPHTHALMOLOGY	18
66165	Fistulization of sclera for glaucoma; iridencleisis or iridotasis	OPHTHALMOLOGY	18
66220	Repair of scleral staphyloma; without graft	OPHTHALMOLOGY	18
66505	Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe	OPHTHALMOLOGY	18
66605	Iridectomy, with corneoscleral or corneal section; with cyclectomy	OPHTHALMOLOGY	18
66700	Ciliary body destruction; diathermy	OPHTHALMOLOGY	18
66920	Removal of lens material; intracapsular	OPHTHALMOLOGY	18
67250	Scleral reinforcement (separate procedure); without graft	OPHTHALMOLOGY	18
67334	Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)	OPHTHALMOLOGY	18
67340	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)	OPHTHALMOLOGY	18
67350	Biopsy of extraocular muscle	OPHTHALMOLOGY	18
67415	Fine needle aspiration of orbital contents	OPHTHALMOLOGY	18
67430	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of foreign body	OPHTHALMOLOGY	18
67440	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with drainage	OPHTHALMOLOGY	18
67599	Unlisted procedure, orbit	OPHTHALMOLOGY	18
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	OPHTHALMOLOGY	18
68500	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total	OPHTHALMOLOGY	18
68505	Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial	OPHTHALMOLOGY	18
68510	Biopsy of lacrimal gland	OPHTHALMOLOGY	18
68540	Excision of lacrimal gland tumor; frontal approach	OPHTHALMOLOGY	18
68550	Excision of lacrimal gland tumor; involving osteotomy	OPHTHALMOLOGY	18
68745	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube	OPHTHALMOLOGY	18
68770	Closure of lacrimal fistula (separate procedure)	OPHTHALMOLOGY	18
69155	Radical excision external auditory canal lesion; with neck dissection	OTOLARYNGOLOGY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
69300	Otoplasty, protruding ear, with or without size reduction	OTOLARYNGOLOGY	04
69320	Reconstruction external auditory canal for congenital atresia, single stage	OTOLARYNGOLOGY	04
69405	Eustachian tube catheterization, transtympanic	OTOLARYNGOLOGY	04
69501	Transmastoid antrotomy (simple mastoidectomy)	OTOLARYNGOLOGY	04
69511	Mastoidectomy; radical	OTOLARYNGOLOGY	04
69530	Petrous apicectomy including radical mastoidectomy	OTOLARYNGOLOGY	04
69550	Excision aural glomus tumor; transcanal	OTOLARYNGOLOGY	04
69552	Excision aural glomus tumor; transmastoid	OTOLARYNGOLOGY	04
69554	Excision aural glomus tumor; extended (extratemporal)	OTOLARYNGOLOGY	04
69601	Revision mastoidectomy; resulting in complete mastoidectomy	OTOLARYNGOLOGY	04
69602	Revision mastoidectomy; resulting in modified radical mastoidectomy	OTOLARYNGOLOGY	04
69603	Revision mastoidectomy; resulting in radical mastoidectomy	OTOLARYNGOLOGY	04
69604	Revision mastoidectomy; resulting in tympanoplasty	OTOLARYNGOLOGY	04
69605	Revision mastoidectomy; with apicectomy	OTOLARYNGOLOGY	04
69650	Stapes mobilization	OTOLARYNGOLOGY	04
69670	Mastoid obliteration (separate procedure)	OTOLARYNGOLOGY	04
69676	Tympanic neurectomy	OTOLARYNGOLOGY	04
69700	Closure postauricular fistula, mastoid (separate procedure)	OTOLARYNGOLOGY	04
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	OTOLARYNGOLOGY	04
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	OTOLARYNGOLOGY	04
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	OTOLARYNGOLOGY	04
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	OTOLARYNGOLOGY	04
69725	Decompression facial nerve, intratemporal; including medial to geniculate ganglion	OTOLARYNGOLOGY	04
69740	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion	OTOLARYNGOLOGY	04
69745	Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion	OTOLARYNGOLOGY	04

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
69802	Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); with mastoidectomy	OTOLARYNGOLOGY	04
69805	Endolymphatic sac operation; without shunt	OTOLARYNGOLOGY	04
69820	Fenestration semicircular canal	OTOLARYNGOLOGY	04
69840	Revision fenestration operation	OTOLARYNGOLOGY	04
69905	Labyrinthectomy; transcanal	OTOLARYNGOLOGY	04
69915	Vestibular nerve section, translabyrinthine approach	OTOLARYNGOLOGY	04
69950	Vestibular nerve section, transcranial approach	OTOLARYNGOLOGY	04
69955	Total facial nerve decompression and/or repair (may include graft)	OTOLARYNGOLOGY	04
69960	Decompression internal auditory canal	OTOLARYNGOLOGY	04
69970	Removal of tumor, temporal bone	OTOLARYNGOLOGY	04
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	DIAGNOSTIC RADIOLOGY	30
74235	Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation	DIAGNOSTIC RADIOLOGY	30
74440	Vasography, vesiculography, or epididymography, radiological supervision and interpretation	UROLOGY	34
74445	Corpora cavernosography, radiological supervision and interpretation	UROLOGY	34
74710	Pelvimetry, with or without placental localization	DIAGNOSTIC RADIOLOGY	30
75803	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation	DIAGNOSTIC RADIOLOGY	30
75805	Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation	DIAGNOSTIC RADIOLOGY	30
75807	Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation	DIAGNOSTIC RADIOLOGY	30
75810	Splenoportography, radiological supervision and interpretation	DIAGNOSTIC RADIOLOGY	30
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation	DIAGNOSTIC RADIOLOGY	30
75880	Venography, orbital, radiological supervision and interpretation	DIAGNOSTIC RADIOLOGY	30
76150	Xeroradiography	ORTHOPEDIC SURGERY	20
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	DIAGNOSTIC RADIOLOGY	30
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	OB-GYN	16

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study	OB-GYN	16
76885	Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)	DIAGNOSTIC RADIOLOGY	30
76886	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)	DIAGNOSTIC RADIOLOGY	30
76940	Ultrasound guidance for, and monitoring of, visceral tissue ablation	DIAGNOSTIC RADIOLOGY	30
76941	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	OB-GYN	16
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation	OB-GYN	16
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	OB-GYN	16
78135	Red cell survival study; differential organ/tissue kinetics, (eg, splenic and/or hepatic sequestration)	DIAGNOSTIC RADIOLOGY	30
78160	Plasma radioiron disappearance (turnover) rate	DIAGNOSTIC RADIOLOGY	30
78170	Radioiron red cell utilization	NUCLEAR MEDICINE	36
78230	Salivary gland imaging;	NUCLEAR MEDICINE	36
78231	Salivary gland imaging; with serial images	NUCLEAR MEDICINE	36
78232	Salivary gland function study	NUCLEAR MEDICINE	36
78351	Bone density (bone mineral content) study, one or more sites; dual photon absorptiometry, one or more sites	DIAGNOSTIC RADIOLOGY	30
78647	Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT)	DIAGNOSTIC RADIOLOGY	30
78890	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes	NUCLEAR MEDICINE	36
78891	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; complex manipulations and interpretation, exceeding 30 minutes	NUCLEAR MEDICINE	36
79200	Radiopharmaceutical therapy, by intracavitary administration	DIAGNOSTIC RADIOLOGY	30
79440	Radiopharmaceutical therapy, by intra-articular administration	DIAGNOSTIC RADIOLOGY	30
88125	Cytopathology, forensic (eg, sperm)	PATHOLOGY	22
88349	Electron microscopy; scanning	PATHOLOGY	22
88355	Morphometric analysis; skeletal muscle	PATHOLOGY	22
89132	Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology; after stimulation	GASTROENTEROLOGY	10
89135	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); one hour	GASTROENTEROLOGY	10

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
89136	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); two hours	GASTROENTEROLOGY	10
89140	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); two hours including gastric stimulation (eg, histalog, pentagastrin)	GASTROENTEROLOGY	10
90829	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services	PSYCHIATRY	26
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	PSYCHIATRY	26
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes	PSYCHIATRY	26
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	PSYCHIATRY	26
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	PSYCHIATRY	26
91060	Gastric saline load test	GASTROENTEROLOGY	10
91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	GASTROENTEROLOGY	10
92015	Determination of refractive state	OPTOMETRY	41
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	OPTOMETRY	41
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	OPTOMETRY	41
92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes	OPTOMETRY	41

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens	OPTOMETRY	41
92335	Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation	OPHTHALMOLOGY	18
92340	Fitting of spectacles, except for aphakia; monofocal	OPTOMETRY	41
92341	Fitting of spectacles, except for aphakia; bifocal	OPTOMETRY	41
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal	OPTOMETRY	41
92352	Fitting of spectacle prosthesis for aphakia; monofocal	OPTOMETRY	41
92353	Fitting of spectacle prosthesis for aphakia; multifocal	OPTOMETRY	41
92354	Fitting of spectacle mounted low vision aid; single element system	OPTOMETRY	41
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	OPTOMETRY	41
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	OPTOMETRY	41
92370	Repair and refitting spectacles; except for aphakia	OPTOMETRY	41
92371	Repair and refitting spectacles; spectacle prosthesis for aphakia	OPTOMETRY	41
92573	Lombard test	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92596	Ear protector attenuation measurements	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92601	Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92602	Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent reprogramming	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	OTOLARYNGOLOGY	04
92613	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only	OTOLARYNGOLOGY	04
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	OTOLARYNGOLOGY	04
92615	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only	OTOLARYNGOLOGY	04
92617	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; physician interpretation and report only	OTOLARYNGOLOGY	04
92970	Cardioassist-method of circulatory assist; internal	CARDIOLOGY	06
92977	Thrombolysis, coronary; by intravenous infusion	CARDIOLOGY	06

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
92990	Percutaneous balloon valvuloplasty; pulmonary valve	CARDIOLOGY	06
92992	Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)	CARDIOLOGY	06
92993	Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)	CARDIOLOGY	06
92997	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel	CARDIOLOGY	06
92998	Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	CARDIOLOGY	06
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	CARDIOLOGY	06
93615	Esophageal recording of atrial electrogram with or without ventricular electrogram(s);	CARDIOLOGY	06
93890	Transcranial Doppler study of the intracranial arteries; vasoreactivity study	NEUROLOGY	13
94150	Vital capacity, total (separate procedure)	PULMONARY DISEASE	29
95071	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify	ALLERGY/IMMUNOLOGY	03
95130	Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; single stinging insect venom	ALLERGY/IMMUNOLOGY	03
95132	Professional services for allergen immunotherapy in prescribing physicians office or institution, including provision of allergenic extract; three stinging insect venoms	ALLERGY/IMMUNOLOGY	03
95858	Tensilon test for myasthenia gravis; with electromyographic recording	NEUROLOGY	13
95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	NEUROLOGY	13
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	NEUROLOGY	13
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	NEUROLOGY	13
96000	Comprehensive computer-based motion analysis by video-taping and 3-D kinematics;	PHYSICAL THERAPIST (INDEP. PRACTICE)	65
96003	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle	PHYSICAL THERAPIST (INDEP. PRACTICE)	65
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	HEMATOLOGY/ONCOLOGY	83

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)	GASTROENTEROLOGY	10
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality	DERMATOLOGY	07
97010	Application of a modality to one or more areas; hot or cold packs	PHYSICAL THERAPIST (INDEP. PRACTICE)	65
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions	CHIROPRACTIC	35
99141	Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation	PEDIATRIC MEDICINE	37
99142	Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal	PEDIATRIC MEDICINE	37
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma	PEDIATRIC MEDICINE	37
99175	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	FAMILY PRACTICE	08
99186	Hypothermia; total body	NEUROLOGY	13
99290	Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; each additional 30 minutes (List separately in addition to code for primary service)	PEDIATRIC MEDICINE	37
99293	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	PEDIATRIC MEDICINE	37
99296	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less	PEDIATRIC MEDICINE	37
99298	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	PEDIATRIC MEDICINE	37
99299	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)	PEDIATRIC MEDICINE	37

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
99374	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99375	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99377	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
99378	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99379	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99380	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; infant (age under 1 year)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years	PEDIATRIC MEDICINE/FAMILY MEDICINE	11/08
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years	PEDIATRIC MEDICINE/FAMILY MEDICINE	11/08
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 65 years and over	PEDIATRIC MEDICINE/FAMILY MEDICINE	11/08

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age under 1 year)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years	INTERNAL MEDICINE/FAMILY MEDICINE	11/08

Review of CPT Codes with Medicare Utilization of fewer than 100 per year - Recommended Specialty to use in PLI methodology

CPT Code	CPT Descriptor	Recommended Specialty for PLI Methodology	Rec. Medicare ID
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 65 years and over	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes	INTERNAL MEDICINE/FAMILY MEDICINE	11/08
99431	History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99433	Subsequent hospital care, for the evaluation and management of a normal newborn, per day	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99435	History and examination of the normal newborn infant, including the preparation of medical records. (This code should only be used for newborns assessed and discharged from the hospital or birthing room on the same date.)	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99436	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08
99440	Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	PEDIATRIC MEDICINE/FAMILY MEDICINE	37/08

AMA
AMERICAN
MEDICAL
ASSOCIATION

February 27, 2006

Terry Kay
Centers for Medicare and Medicaid Services
7500 Security Blvd, C4-01-15
Baltimore, MD 21244

Dear Mr. Kay,

In the 2004 November 15 *Final Rule*, CMS indicated that the agency was interested in RUC input on the appropriateness of the PLI crosswalk assumptions. The risk factors are currently set at the all physician risk factor for the professions indicated below. The RUC requested the PLI risk factor be set to 1.00 ($6,100) for the following eight health professionals and that CMS investigate other data as $6,100 most likely over estimates the PLI premium for these professions. The RUC also invited these professions to present evidence that their annual PLI premiums are greater than $6,100. These professions include:

- Clinical Psychologist
- Licensed Clinical Social Worker
- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

The HCPAC professions made their best effort to gather information on the collection of PLI premium data and submitted it to the HCPAC at the September 29, 2005, meeting. The professions indicated above, except opticians/optometry, submitted PLI premium data to the HCPAC. Subsequently, the HCPAC submitted this data to CMS in a letter dated October 6, 2005. However, the letter did not include data from opticians/optometry.

At the February 2, 2006, HCPAC meeting, the American Optometric Association (AOA) had PLI premium data available and submitted it the HCPAC. The HCPAC believes that the yearly average PLI premium data per profession indicated in the following table is now complete, accurate and should be utilized in determining the risk factors for use in the PLI methodology. The CMS assumption of $6,100 per year overestimates the actual PLI premium data and results in an underestimation of the PLI risk factors for physician specialties.

Specialty Society	Average Yearly Premium	Yearly Premium Range
American Chiropractic Association	$1,870 (in 2005)	Up to $4,000 - $6,000 (New York averages $4,000 and Florida $6,000)
American Occupational Therapy Association		$250 - $1,000 (in 2004/2005)
American Psychological Association	$1,500	
American Physical Therapy Association	$1,100 (2005) $1,500 (projected for 2006)	
American Speech-Language-Hearing Association	$700 (Typical private practice with hearing aid dispensing capabilities)	$62 (Individual) $167 (Group)
National Association of Social Workers	$500	
American Optometric Association		$500 to $2,000
American Dietetic Association		$118-$144 (hospital facility) $900 (small practice)

Following the February 2, 2006, HCPAC meeting, the American Optometric Association informed AMA staff that they were recently informed that PLI premiums for optometrists are to increase ranging from $511.00 to $4,800.00. The HCPAC reviewed and approved the initial premium range of $500.00 to $2,000.00 submitted by AOA. However, enclosed are both letters submitted from AOA.

Enclosed are the letters each specialty submitted to the RUC HCPAC.

Sincerely,

Richard W. Whitten, MD, FACP
HCPAC Chair

Mary Foto, OTR
HCPAC Co-Chair

cc: Carolyn Mullen
Rick Ensor
Stephanie Monroe
HCPAC Participants

American Optometric Association
1505 Prince Street • Alexandria, VA 22314 • (703) 739-9200
FAX: (703) 739-9497

January 31, 2006

Richard W. Whitten, MD, Chair
Health Care Professionals Advisory Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Doctor Whitten:

In late 2004, the RUC PLI workgroup recommended changes in the professional liability insurance (PLI) risk factor for eight specialties including optometry to 1.0 based on conventional wisdom that actual premiums for these specialties were less than the $6,200 represented by the 1.0 risk factor. In the 2005 PFS optometry was assigned a PLI risk factor of 2.35 (cross walked to the non-surgical risk factor for ophthalmology) as recommended in the August 2004 Bearing Point report. The workgroup requested the affected specialties provide premium data to refute the requested change.

The American Optometric Association opposed the proposed change in the PLI risk factor for optometry based on "conventional wisdom" and has attempted to obtain valid representative data of PL insurance premiums for optometry. We have contacted several different insurance carriers who provide PL for optometrists and have either had no response or they have declined to provide premium data.

Informal information obtained from a variety of providers regarding premium data for optometry reflects a wide variety of practice patterns, different demographics and the non-uniform scope of practice for optometry across the country. We have concluded it is not possible for AOA to accurately determine a precise estimate of premium data for optometry. Nonetheless, we can provide the following information based on our informal survey of providers. Most optometrists have professional liability premiums ranging from $500.00 to $2,000.00 per year. We realize that some practitioners have premiums lower than this and that some have premiums in excess of this estimate.

The AOA would appreciate the opportunity to submit additional evidence supporting a different range of professional liability premiums if future data supports this. Therefore, we would ask the RUC to ask CMS to refine its PLI risk factor for optometry should that happen. Thank you.

Sincerely,

Christopher J. Quinn, OD
Member, RUC/HCPAC

American Optometric Association
1505 Prince Street, Alexandria, VA 22314•(703) 739-9200
FAX: (703) 739-9497

February 8, 2006

Richard W. Whitten, MD, Chair
Health Care Professionals Advisory Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Doctor Whitten:

In late 2004, the RUC PLI workgroup recommended changes in the professional liability insurance (PLI) risk factor for eight specialties including optometry to 1.0 based on conventional wisdom that actual premiums for these specialties were less than the $6,200 represented by the 1.0 risk factor. In the 2005 PFS optometry was assigned a PLI risk factor of 2.35 (cross walked to the non-surgical risk factor for ophthalmology) as recommended in the August 2004 Bearing Point report. The workgroup requested the affected specialties provide premium data to refute the requested change.

The American Optometric Association opposed the proposed change in the PLI risk factor for optometry based on "conventional wisdom" and has attempted to obtain valid representative data of PL insurance premiums for optometry. We have contacted several different insurance carriers who provide PL for optometrists and have either had no response or they have declined to provide premium data.

Informal information obtained from a variety of providers regarding premium data for optometry reflects a wide variety of practice patterns, different demographics and the non-uniform scope of practice for optometry across the country. We have concluded it is not possible for AOA to accurately determine a precise estimate of premium data for optometry. Nonetheless, we can provide the following information based on our informal survey of providers. Most optometrists have professional liability premiums ranging from $511.00 to $4,800.00 per year. We realize that some practitioners have premiums lower than this and that some have premiums in excess of this estimate.

The AOA would appreciate the opportunity to submit additional evidence supporting a different range of professional liability premiums if future data supports this. Therefore, we would ask the RUC to ask CMS to refine its PLI risk factor for optometry should that happen. Thank you.

Sincerely,

Christopher J. Quinn, OD
Member, RUC/HCPAC

American Chiropractic Association

DEDICATED TO IMPROVING THE HEALTH AND WELLNESS OF AMERICA, NATURALLY.

September 1, 2005

Sherry Smith
American Medical Association
RBRVS Update Committee
515 North State Street
Chicago, IL 60610

Dear Sherry,

This letter is in response to the RUC HCPAC request for data relative to Professional Liability premium levels paid by the chiropractic profession. To this end we contacted the National Chiropractic Mutual Insurance Corporation (NCMIC) for some insight into current premium levels. We believe this particular company has the largest number of insureds in the country.

According to Mr. Rod E. Warren, chief operating officer of NCMIC, in 2005 the average doctor of chiropractic will pay approximately $1870.00 in annual premiums (an arithmetic mean). A number of factors go into this premium average, including discounts for new practitioners, claims made step factors and limits selected. Per Mr. Warren, it is important to note that the range of premium rates is skewed and broad with a significant number of insureds paying much higher premiums, typically in the $4,000-6,000 range. For example Florida chiropractors pay an average of $6,000, while those in New York pay an average of $4,000. As these numbers demonstrate, the average we cited is accurate but not necessarily a good representation of the actual premium paid by many chiropractors.

The American Chiropractic Association along with NCMIC feels that our profession is practicing sound patient care, excellent interpersonal skills and solid risk management practices thus decreasing lawsuits and lowering the cost of professional liability insurance premiums.

Should you need further information, please feel free to contact me personally.

Sincerely,

Anthony W. Hamm, D.C.

Anthony W. Hamm, DC
American Chiropractic Association

AOTA® The American Occupational Therapy Association, Inc.

Via Facsimile

August 31, 2005

Susan Dombrowski
American Medical Association
Relative Value Update Committee
515 N. State Street
Chicago, IL 6061

Dear Susan,

The American Occupational Therapy Association (AOTA) requested professional liability insurance (PLI) information from members and also attempted to obtain data from some of the insurance carriers. The information received varied widely. Certainly, we can definitely state that the amount is considerably less than the $6,100 floor.

Self-employed occupational therapists provided premium information that ranged from about $250 to $1,000 in 2004/2005. Therapists report increases of 50% to 200% over the past 3 years. There also seems to be a differential related to geographic location.

I'm sorry that we were unable to obtain more definitive data, but found that insurers are very reluctant to provide current numbers, and PLI rates appear to be moving targets. Please let me know if you would like us to pursue further.

Sincerely,

Judy Thomas
Senior Policy Manager

APTA
American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703.684.2782
703.684.7343 fax
www.apta.org

August 24, 2005

Sherry Smith
American Medical Association
Relative Value Update Committee
515 North State Street
Chicago, IL 60610

Dear Sherry,

In response to the charge of the HCPAC to seek data regarding the professional liability insurance paid by physical therapists, we have checked with those insurers who cover such risks. They have indicated that they are not willing to publicly release their costs/prices.

To obtain at least a view of the professional liability costs that are borne by physical therapists, we made contact with several therapists and discussed the rates that they are paying. There was an interesting variation, seeming to be centered on when they had received their most recent annual billing. Increases of 50% in a given year were not uncommon. It would appear that annual rates for typical physical therapist practices are approximately $1,100 per therapist per year (in a $1 million/ $3 million, no claims made history) for renewals currently being received.

To further verify this value, we spoke with numerous therapists at our recent Annual Conference in Boston. For those who have not received their annual premium for 2005, the numbers were significantly lower; however, one therapist shared that her practice had, over the last three years, increased from less than $500 per therapist in 2003, to $750 in 2004 and to over $1,100 in 2005 (again, in a $1-3 million, no claims made environment).

While this information may be considered anecdotal, I am not sure, given the rate of increase, that precision is possible - whatever is calculated in one month will be out of date three months later. However, I do believe that the figure of $1,100 per therapist for 2005 is far more accurate than the current figure of $6,100 that is being used.

I would further suggest, given the rate of increase of the last several years, that an appropriate amount for 2006 is going to be in the neighborhood of $1,500 per therapist, and would request that this figure be considered for calculations for the 2006 professional liability component.

Sincerely,

James J. Nugent
American Physical Therapy Association

From: "Coleman, Mirean" <MColeman@naswdc.org>
To: "Susan Dombrowski" <Susan_Dombrowski@ama-assn.org>
Date: 03/22/05 11:30:57 AM
Subject: RE: PLI for Clinical Social Workers

Hi Susan:

The average annual premium is approximately $500.00.

Mirean Coleman, MSW, LICSW, CT
Senior Policy Associate
National Association of Social Workers
202-336-8265

-----Original Message-----
From: Susan Dombrowski [mailto:Susan_Dombrowski@ama-assn.org]
Sent: Tuesday, March 22, 2005 12:15 PM
To: Coleman, Mirean
Subject: Re: PLI for Clinical Social Workers

Hi Mirean,

Does NASW have an average national amount for what the annual premium is for clinical social workers?

Sincerely,

Susan Dombrowski
Physician Payment Policy and Systems
American Medical Association
515 N. State Street
Chicago, Illinois 60610
Susan.Dombrowski@ama-assn.org
312.464.4308
312.464.5849 Fax

>>> "Coleman, Mirean" <MColeman@naswdc.org> 03/22/05 9:43:41 AM >>>

Good Morning Susan:

Clinical social workers have an annual premium that is far below $6,100. Therefore, our risk factor should remain at 1. Please let me know if you have any questions about this or require additional information. Thanks!

Mirean Coleman, MSW, LICSW, CT
Senior Policy Associate
National Association of Social Workers
202-336-8265

From: "Moore, Kimberley" <kmoore@apa.org>
To: <Susan_Dombrowski@ama-assn.org>
Date: 08/31/05 11:53:59 AM
Subject: Liability Rates for psychologists

Hi Susan,

I checked with our liability insurance company on the average cost of premiums for psychologists. It is approximately $1,500.

Also, Medicare listed "clinical psychologists" and "psychologists." Those are delineations that Medicare makes. The liability premium data is the same for either classification.

Kimberley Moore
Federal Regulatory Affairs Officer
Govt. Relations Dept.
American Psychological Association
750 First St. NE
Washington, DC 20002
202.336.5889 ph.
KMoore@apa.org

UNIVERSITY OF Miami
SCHOOL OF MEDICINE

September 1, 2005

Susan Dombrowski
American Medical Association
Relative Value Update Committee
515 North State Street
Chicago, IL 60610

Dear Susan:

We were able to examine PLI premium data from a primary carrier of liability coverage for audiologists and speech-language pathologists to obtain an estimate of our PLI expenses for you. Our expenses in this area are much lower than many professional disciplines primarily because we, both audiology and speech-language pathology, are rarely sued for malpractice. That situation is changing somewhat with our professions moving from strictly the clinical setting into the operating room setting for neurophysiological intraoperative monitoring of patients undergoing neurosurgical procedures. However, our rates are still very modest with an individual premium costing $62.00 for $1,000,000/$3,000,000 coverage. The owner of a group practice pays $167.00 for personal coverage with $2,000,000/$5,000,000 limits. However, the group practice owner commonly must also provide coverage for each professional employee and each facility that requires by contract listing the facility as an additional insured. If hearing aids are dispensed, an additional premium is required. As a result, a typical private practice with a principle owner, four professional staff, contracts with two outside facilities and hearing aid dispensing capabilities would pay a premium of approximately $700.00 per year in PLI expenses.

Sincerely,

Robert Fifer PhD

Robert C. Fifer, Ph.D.
HCPAC Representative
American Speech-Language-Hearing Association

Mailman Center for Child Development D-820
Department of Pediatrics
Division of Audiology
Tel: (305) 243-5937
Division of Speech-Language Pathology
Tel: (305) 243-6204
1601 N. W. 12th Avenue
Miami, Florida 33136
Fax: (305) 243- 6921

American Dietetic Association
Your link to nutrition and health.[sm]

120 South Riverside Plaza, Suite 2000
Chicago, IL 60606-6995
800/877-1600
www.eatright.org

Policy Initiatives and Advocacy
1120 Connecticut Avenue, Suite 480
Washington, DC 20036-3989
202/775-8277 FAX 202/775-8284

September 26, 2005

Susan Dombrowski
American Medical Association
Relative Value Update Committee
515 N. State Street
Chicago, IL 60610

Dear Susan:

The American Dietetic Association requested professional liability insurance (PLI) information from some of our members and also reviewed rates from two of the main vendors that offers liability insurance to registered dietitians. Of the data we received, we noticed considerable variability in the rates depending on the size of the RD practice, the employment setting and the amount of coverage selected. The yearly premium range for an individual RD, who obtains additional liability coverage over and above the coverage available at the hospital facility where the RD is employed for greater than 20 hours per week, is approximately $144-$118. Whereas an RD who is self-employed and owns a small practice with 2 RD FTEs may have a premium of approximately $900 or more.

Similar to other non-physician practitioners, ADA believes CMS should set the risk factor to 1.00 for RDs who provide medical nutrition therapy services.

Sincerely,
Jane White, PhD, RD, FADA
American Dietetic Association HCPAC RUC representative

Cc: Pam Michael, ADA Nutrition Services Coverage Team

Physician Time Components New and Revised Codes - September 2005 and February 2006

code	rvw	Pre-Service Evalutation	Pre-Service Postioning	Pre-Service Scrub Dress	Intra Service	Imme diate Post	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time
17004	2.20	5			20	5									1				45
228X1	28.95	60	20	15	180	45			1	2		1				4			527
228X2	36.00	70	20	15	240	45			1	2		1				4			679
228X3	35.00	75	20	15	210	30			2	2		1				4			617
2561X1	8.00	40	10	15	45	30						0.5			2	3			257
2561X2	9.00	40	10	15	60	30						0.5			2	3			272
2561X3	11.25	40	10	15	90	30						0.5			2	3			302
2561X4	15.00	40	10	15	120	30						0.5			2	4			355
44141	27.00	45	20	15	160	45			4	2		1			1	1	1		615
44144	27.00	45	20	15	165	45			4	2		1			1	1	1		620
44145	26.38	60	20	15	180	45			3	2		1			1	2			575
44146	33.00	60	20	15	240	45			3	2		1			1	1	1		650
44147	31.00	60	20	15	220	45			3	2		1			1	2			656
4415X1	33.00	30	15	15	240	45			5	3		1			1	2	1		706
4415X2	34.00	30	15	15	260	45			5	3		1			1	2	1		726
558XX	1.73	19	10		20	10													59
572XX1	15.02	45	10	10	120	40			2	2		1				2			405
585XX1	15.94	45	10	5	120	30			2			1			1	2			345
585XX2	17.44	45	10	5	135	30			2			1			1	2			360
585XX3	13.77	45	10	5	95	30			2			1			1	2			320
585XX4	15.63	45	10	5	110	30			2			1			1	2			335
705X54	2.11	15			35	10													60
705X55	2.54	10			45	10													65
7677X	0.90	5			10	5													20
768XX1	1.18	5			20	10													35
768XX2	0.99				20														20
9604X1	3.43	10			60	10													80
33548	49.41	60	15	20	217	40	2	1	1	2	3		1			2	1		841
92XXX	0.35	5			12														17

February 28, 2006

Carolyn Mullen
Deputy Director, Division of Practitioner Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop C4-03-06
Baltimore, Maryland 21244

Dear Ms. Mullen:

On behalf of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), I have enclosed our final work relative value recommendations for the following Five-Year Review of the Resource-Based Relative Value issues considered at our February meeting:

- Evaluation and Management (E/M) Services
- Destruction of Lesions
- Colectomy
- Cardiothoracic Surgery – Physician Time Updates Only

In addition, we have enclosed a spreadsheet with RUC recommended physician time and work relative values for all services, including those codes with a 010 and 090 day global period, to incorporate increases in the E/M services.

The RUC appreciates this opportunity to review the comments submitted in this Five-Year Review. We believe that our recommendations, if implemented, would further improve the RBRVS payment system.

Sincerely,

William L. Rich, III, MD, FACS

Enclosures

cc: Rick Ensor
Edith Hambrick, MD
Ken Simon, MD
Pam West

RUC E/M Recommendations - Five-Year Review of the RBRVS - February 2006

	Existing Data - RUC database					CPT	RUC Recommended Physician Time				RUC Recommended	E/M Content		
Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Time	Pre- Time	Intra Time	Post Time	Total Time	Work RVU	History	Exam	Medical Decision Making
Office, new														
99201		10		15	0.45	10	2	10	5	17	**0.45**	problem focused	problem focused	straight-forward
99202		20		30	0.88	20	2	15	5	22	**0.88**	expanded problem focused	expanded problem focused	straight-forward
99203	5	24	24	53	1.34	30	4	20	5	29	**1.34**	detailed	detailed	low
99204		45		68	2.00	45	5	30	10	45	**2.30**	comprehensive	comprehensive	moderate
99205	10	45	55	110	2.67	60	7	45	15	67	**3.00**	comprehensive	comprehensive	high
Office, estabablished														
99211		5	2	7	0.17	5	0	5	2	7	**0.17**			
99212		10	5	15	0.45	10	2	10	4	16	**0.45**	problem focused	problem focused	straight-forward
99213		15	8	23	0.67	15	3	15	5	23	**0.92**	expanded problem focused	expanded problem focused	low
99214		25	13	38	1.10	25	5	25	10	40	**1.42**	detailed	detailed	moderate
99215		40	19	59	1.77	40	5	35	15	55	**2.00**	comprehensive	comprehensive	high
Initial hospital														
99221		30		43	1.28	30	10	30	10	50	**1.88**	detailed or comprehensive	detailed or comprehensive	straight-forward or low
99222		50		71	2.14	50	15	40	20	75	**2.56**	comprehensive	comprehensive	moderate
99223	10	45	50	105	2.99	70	15	55	20	90	**3.78**	comprehensive	comprehensive	high
Subsequent hospital														
99231		15	4	19	0.64	15	5	10	5	20	**0.76**	problem focused	problem focused	straight-forward or low
99232		25	5	30	1.06	25	10	20	10	40	**1.39**	expanded problem focused	expanded problem focused	moderate
99233		35	6	41	1.51	35	10	30	15	55	**2.00**	detailed	detailed	high
Hospital discharge														
99238	6	18	12	36	1.28	30 or less	8	20	10	38	**1.28**			
99239	9	20	16	45	1.75	more than 30	10	30	15	55	**1.90**			
Office consultation														
99241		15		23	0.64	15	5	15	5	25	**0.64**	problem focused	problem focused	straight-forward
99242		30		45	1.29	30	5	25	10	40	**1.34**	expanded problem focused	expanded problem focused	straight-forward
99243	5	30	31	66	1.72	40	5	28	7	40	**1.88**	detailed	detailed	low
99244		60		88	2.58	60	10	40	15	65	**3.02**	comprehensive	comprehensive	moderate
99245	10	48	50	108	3.42	80	10	60	20	90	**3.77**	comprehensive	comprehensive	high
Inpatient consultation														
99251		20		26	0.66	20	5	10	5	20	**1.00**	problem focused	problem focused	straight-forward
99252		32		42	1.32	40	5	25	10	40	**1.50**	expanded problem focused	expanded problem focused	straight-forward
99253	10	30	35	75	1.82	55	10	30	15	55	**2.27**	detailed	detailed	low
99254		65		84	2.64	80	15	45	20	80	**3.29**	comprehensive	comprehensive	moderate
99255	15	45	57	117	3.64	110	20	60	25	105	**4.00**	comprehensive	comprehensive	high
Emergency visit														
99281		10		11	0.33	N/A	2	7	4	13	**0.45**	problem focused	problem focused	straight-forward
99282		15		16	0.55	N/A	3	10	5	18	**0.88**	expanded problem focused	expanded problem focused	low
99283		25		26	1.24	N/A	5	18	7	30	**1.34**	expanded problem focused	expanded problem focused	moderate
99284		40		42	1.95	N/A	5	25	10	40	**2.56**	detailed	detailed	moderate
99285		50		53	3.06	N/A	8	40	15	63	**3.80**	comprehensive	comprehensive	high
Critical care														
99291	15	45	15	75	3.99	30–74	15	40	15	70	**4.50**			

	Existing Data - RUC database					CPT	RUC Recommended Physician Time				RUC Recommended	E/M Content		
Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Time	Pre- Time	Intra Time	Post Time	Total Time	Work RVU	History	Exam	Medical Decision Making
99292		30		30	2.00	each addl 30		30		30	**2.25**			

	Existing Data - RUC database					CPT	RUC Recommended Physician Time				RUC Recommended	E/M Content		
Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Time	Pre- Time	Intra Time	Post Time	Total Time	Work RVU	History	Exam	Medical Decision Making
Reference Codes														
45340	17	25	16	58	1.89									
60100	15	25	10	50	1.56									
76005	10	20	5	35	0.60									
90801	10	60	55	125	2.80									
90847	5	50	21	76	2.21									
90880	8	50	40	98	2.19									
93307	5	18	5	28	0.92									
93503	20	30	45	95	2.91									
95810	15	60	20	95	3.52									
95903	8	10	10	28	0.60									
97110	2	14	2	18	0.45									
99217	10	30	15	55	1.28									
99234	10	60	15	85	2.56									
99235	10	75	15	100	3.41									
99236				110	4.26									
99299	10	30	15	55	2.50									
99341	6.5	20	10	36.5	1.01									
99342	10	30	12	52	1.52									
99343	15	50	17	82	2.27									
99344	15	60	25	100	3.03									
99345	15	90	30	135	3.78									
99347	5	15	10	30	0.76									
99348	9	30	10	49	1.26									
99349	10	40	15	65	2.02									
99350	15	72	20	107	3.03									
99375	10	32	15	57	1.73									
99386	5	40	10	55	1.88									
99387	5	45	10	60	2.06									
99396	5	30	10	45	1.53									
99433	3	15	2	20	0.62									