AMA/Specialty RVS Update Committee
Meeting Minutes
January 29-31, 2009

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Friday, January 30, 2009, at 9:00 am. The following RUC Members were in attendance:

William Rich, MD (Chair)
Bibb Allen, MD
Michael D. Bishop, MD
James Blankenship, MD
R. Dale Blasier, MD
Joel Bradley, MD
Ronald Burd, MD
Thomas Cooper, MD
Thomas A. Felger, MD
John Gage, MD
David Hitzeman, DO
Peter Hollmann, MD
Charles F. Koopmann, Jr., MD
Gregory Kwasny, MD
Brenda Lewis, DO
J. Leonard Lichtenfled, MD
Barbara Levy, MD
Lawrence Martinelli, MD
Bill Moran, Jr., MD
Marc Raphaelson, MD
Gregory Przybylski, MD
Daniel Mark Siegel, MD
Lloyd Smith, DPM
Peter Smith, MD
Samuel Smith, MD
Susan Spires, MD
Arthur Traugott, MD
James Waldorf, MD

Allan Anderson, MD*
Dennis M. Beck, MD*
Edward Bentley, MD*
Jonathan Berlin, MD*
Manuel D. Cerqueira, MD*
Bruce Deitchman, MD*
James Denneny, MD*
Verdi DiSesa, MD*
Emily Hill, PA-C*
Allan Inglis, Jr., MD*
Walter Larimore, MD*
M. Douglas Leahy, MD*
William J. Mangold, Jr., MD*
Daniel McQuillen, MD*
Terry L. Mills, MD*
Scott D. Oates, MD*
Julia Pillsbury, MD*
Sandra B. Reed, MD*
Chad Rubin, MD*
Steven Schlossberg, MD*
Holly Stanley, MD*
Stanley Stead, MD*
Robert Stomel, DO*
J. Allan Tucker, MD*
George Williams, MD*

*Alternate

II. Chair's Report

Doctor Rich made the following general announcements:

- Financial Disclosure Statements for each issue must be submitted to AMA staff prior to its presentation. If a form is not signed prior to the presentation, the individual will not be allowed to present.
- Presenters are expected to announce any conflicts or potential conflicts, including travel reimbursement paid by an entity other than the specialty society, at the onset of their presentation.

- Before a presentation, any RUC member with a conflict must state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or advocate on behalf of their specialty.
- All RUC Advisors are required to sign the attestation statement and submit it with their recommendations to be incorporated into the agenda book.
- Doctor Rich welcomed the CMS staff and representatives attending the meeting, including:
    - Edith Hambrick, MD, CMS Medical Officer
    - Whitney May, Deputy Director, Division of Practitioner Services
    - Ken Simon, MD, CMS Medical Officer
    - Pam West, PT, DPT, MPH, Health Insurance Specialist

- Doctor Rich welcomed the following Medicare Contractor Medical Director:
    - Charles Haley, MD
- Doctor Rich announced the members of the Facilitation Committees:

Facilitation Committee 1	Facilitation Committee 2	Facilitation Committee 3
Bibb Allen, MD (Chairman)	Gregory Kwasny, MD (Chairman)	Katherine Bradley, PhD (Chairman)
Joel Bradley, Jr., MD	Michael Bishop, MD	Edward Bentley, MD
Ron Burd, MD	James Blankenship, MD	John Gage, MD
Thomas Cooper, MD	Dale Blasier, MD	David Hitzeman, DO
Emily Hill, PA-C	Thomas Felger, MD	Charles Koopmann, MD
Peter Hollmann, MD	Barbara Levy, MD	Brenda Lewis, MD
J. Leonard Lichtenfeld, MD	William Mangold, Jr, MD	Lawrence Martinelli, MD
Charles Mick, MD	Marc Raphaelson, MD	Bill Moran, MD
Gregory Przybylski, MD	Lloyd Smith, DPM	Daniel Mark Siegel, MD
Peter Smith, MD	Susan Spires, MD	Arthur Traugott, MD
Samuel Smith, MD	James Waldorf, MD	Robert Zwolak, MD

- Doctor Rich welcomed the following individuals as observers at the January 2009 meeting:
    - Debra Abel – American Academy of Audiology
    - Margie Andreae – American Academy of Pediatrics
    - Brett Baker – American College of Physicians
    - Robert Barr – American Society of Neuroradiology
    - Michael Bigby – American Academy of Dermatology
    - Eileen Brewer, MD – Renal Physicians Association
    - Neil Busis – American Academy of Neurology
    - Scott Collins – American Academy of Dermatology
    - Allan Desmond – American Speech Language Hearing Association
    - Edward Eikman – Society of Nuclear Medicine
    - Jennifer Frazier - American Society for Therapeutic Radiology and Oncology
    - Emily Gardner – American College of Cardiology
    - Denise Garris – American College of Cardiology
    - Richard Gilbert, MD – American Urological Association
    - John Goodson – American College of Physicians
    - Robert Hall – American Association of Hip and Knee Surgeons

- David Han – Society for Vascular Surgery
- Zachary Hochstetler – Society of Nuclear Medicine
- Robert Jasak – American Academy of Orthopaedic Surgeons
- Robert Jones – American College of Cardiology
- Kendall Kodey – American College of Cardiology
- Carrie Kovar – American College of Cardiology
- Katie Kuechemneister – American Academy of Neurology
- Alex Little, MD – Society of Thoracic Surgeons
- Kenneth McKusick, MD – Society of Nuclear Medicine
- Erika Miller – American College of Physicians
- Lisa Miller-Jones – American College of Surgeons
- Dewan Naakesh – American Psychiatric Association
- Gerald Neidzwiecki, MD – Society of Interventional Radiology
- Dee Nikjeh – American Speech Language Hearing Association
- Vinita Ollapally – American College of Surgeons
- Debbie Ramsburg – Society of Interventional Radiology
- John Ratliff, MD – American Association of Neurological Surgeons
- David Regan, MD – American Society of Clinical Oncology
- Paul Rudolf, MD, JD – American Geriatrics Society
- Matthew Sideman, MD – Society for Vascular Surgery
- Ezequiel Silva, MD – Society of Interventional Radiology
- Maurine Spillman-Dennis – American College of Radiology
- James Startzell, MD – American Association of Oral and Maxillofacial Surgeons
- Michael Sutherland – Society for Vascular Surgery
- Tim Tillo – American Podiatric Medical Association
- William van Decker – American College of Cardiology
- Edward Vates, MD – American Association of Neurological Surgeons
- Allison Waxler – North American Spine Society
- Duane Whitaker, MD – American Academy of Dermatology
- Joanne Willer – American Academy of Orthopaedic Surgery
- Kadyn Williams – American Academy of Audiology
- Pamela Woodard – American College of Radiology
- Jennifer Young – American Association of Clinical Endocrinologists

- Doctor Rich and the entire RUC thanked Doctor Thomas Felger for years of service and noted that this is the last meeting for which he will serve on the RUC. Doctor Rich also announced the departure of Doctor James Anthony to whom Doctor Rich wrote a letter thanking him for his service.

III. Director's Report

Sherry Smith made the following announcements:

- Future RUC meeting locations have been confirmed as follows:
  - April 23-26, 2009, RUC Meeting, Swissotel, Chicago, IL
  - October 1-4, 2009, RUC Meeting, Hyatt Regency, Chicago, IL
  - February 4-7, 2010 RUC Meeting, Hilton Bonnet Creek, Orlando, FL

IV. Approval of Minutes for the October 2-5, 2008 RUC Meeting

The RUC approved the minutes without revision.

V. CPT Editorial Panel Update

Doctor Peter Hollmann provided the report of the CPT Editorial Panel:

- The CPT Editorial Panel will be holding its next meeting in Phoenix, AZ February 5-8, 2009. The Panel will be addressing several issues first raised by the RUC's Five Year Review Identification Workgroup.
- Doctor Hollmann reported that the CPT Editorial Panel has begun preliminary discussions to assess the feasibility of creating on on-going process to improve the data for each service. Rather than address services only during one of the three Panel meetings per cycle, the proposed process would allow Panel members to approve editorial revisions and other minor changes outside of Panel meetings. Such a process would help to facilitate editorial changes as well as improve and add clinical vignettes where they are lacking.

VI. Centers for Medicare and Medicaid Services Update

Doctor Ken Simon provided the report of the Centers for Medicare and Medicaid Services (CMS):

- Doctor Simon reported that all political employees of the Agency have departed. CMS is awaiting appointment of the Secretary of Health and Human Services as well as the CMS Administrator.

VII. Carrier Medical Director Update

Doctor Charles Haley updated the RUC on several issues related to Medicare Contractor Medical Directors (CMDs).

- Doctor Haley reported that MAC contracts have been announced for the remaining five contracts on January 7, 2009. The losing bidders have opportunity to protest the awards, therefore the final contractors not yet finalized. The protest period will postpone the final awards for approximately two to three months.
- Doctor Haley also made several comments regarding the inpatient and outpatient issues recently discussed at the RUC meeting. Doctor Haley noted that the place of service field within the RUC database reflects the site of service as indicated on the physician bill. In Medicare Part B, place of service has no real impact on physician work reimbursement or the facility reimbursement. However, in the Part A setting, the difference between inpatient and outpatient status is significant. A change in status incurs different liabilities and rights for the patients as well as the hospitals. By Medicare rules, the decision to admit is determined by the physician order. A hospital review committee can change from inpatient to outpatient based on whatever criteria they establish. Such a change, changes the claim from a Part A to a Part B payment. Hospitals are supposed to submit the changed claim with a "condition code 44," which notifies CMS that the status has changed. Additionally, the hospital is required to notify a physician of the change. The physician need not be the admitting physician.

VIII. Washington Update

Sharon McIlrath, AMA Assistant Director of Federal Affairs, provided the RUC with the following information regarding the AMA's advocacy efforts:

- Ms. McIlrath reported that Tom Daschle has been nominated to serve as the Secretary for Health and Human Services. It is still too soon to predict the next administrator of CMS.
  Staff Note: Tom Daschle subsequently withdrew from consideration. Kathleen Sebelius is the current nominee.
- The AMA has met with Mr. Daschle, in addition to the entire Obama transition team and the new administration's CMS transition team. Thus far, the new administration has listened to the AMA's requests and has shown a willingness to cooperate.
- The new administration has already begun to act on some of its healthcare initiatives as evidence by the recent SCHIP reauthorization bill and the economic stimulus bill. The SCHIP bill reauthorizes SCHIP spending for five years and increases funding by $35 billion. The increase is paid for by increases in tobacco tax. The bill also prohibits SCHIP payment to physician owned hospitals that do not have a Medicare ID number. The AMA does not support this provision.
- The House has recently passed the Economic Recovery and Financial Stability Act. The bill includes $150 billion in healthcare spending. The bill includes provisions to help extend and subsidize COBRA insurance as well provide new money for wellness, prevention, flu pandemic, and primary care services. The bill identifies health information technology as a focus of the new administration, providing $20 billion in spending to help transition to HIT. The bill provides for a five-year period, in which physicians could receive significant monetary incentives to transition to HIT. At the end of five years, those who are not using HIT will have a 1% penalty on Medicare and Medicaid reimbursement. Despite concerns about the punitive incentives and about the use of a PQRI-based format for demonstrating meaningful use of the HIT, the AMA is supporting the bill's HIT provisions because it provides significant funding to support the transition to HIT.
- With the current economic climate, discussion of healthcare reform has increased. The AMA has remained highly active in these discussions and has insisted that the replacing the SGR is of paramount importance. The AMA has been active with legislators and is working to reach a consensus with other interest groups. Early indications point to a large scale reformation of physician payment reform in 2010. The AMA anticipates another fix late this calendar year to forego the impending 21% cut in physician payment. The current administration and Congress understand that the cost of stop gap fixes has become extremely high. According to the Congressional Budget Office, replacing the SGR will cost $439 billion and freezing the SGR for 10 years will cost $318 billion.
- Some lawmakers and the AMA are pushing for a "re-basing" of the Medicare physician payment system. This would eliminate the accumulated cost of all the previous unfunded SGR fixes, wiping out a 21% cut in 2010 and projected cuts of 40% or more over the next several years.
- Lastly, the Acute Care Episode Demonstration project, which combines payment for hospitals and physicians, has awarded demonstration sites. This project will include major cardiac procedures and knee / hip replacement only.

IX. Relative Value Recommendations for CPT 2010

Subcutaneous Excision of Soft Tissue Tumor (Tab 4), Subfascial Excision of Soft Tissue Tumor (Tab 5), Radical Excision of Soft Tissue Tumor (Tab 6), New Excision of Soft Tissue Tumor (Tab 7)

Jane Dillon, MD, American Academy of Otolaryngology – Head and Neck Surgery, Christopher Senkowski, MD, American College of Surgeons, Martha Matthews, MD, American Society of Plastic Surgeons, Dan Nagle, MD, American Society for Surgery of the Hand, William Creevy, MD, American Academy Orthopaedic Surgeons, Tye Ouzonian, MD, American Orthopaedic Foot and Ankle Society, Daniel Nagle, MD, American Society for Surgery of the Hand, Frank Spinosa, DPM, American Podiatric Medical Association

Background:
The American Academy of Orthopaedic Surgery (AAOS) and the Musculoskeletal Tumor Society (MSTS) responded to the Centers for Medicare and Medicaid Services' (CMS) Five-Year Review request for comment on misvalued codes in 1995, arguing that the Hsaio survey had misvalued these services. During the course of this first Five-Year Review process, it became evident that coding changes would be necessary prior to revaluing these services. From 1995-2005, MSTS and AAOS drafted CPT proposals to address issues within the soft tissue tumor excision family and bone tumor family codes but these proposals were rejected by the CPT advisors and/or the CPT Editorial Panel. For the 2005 Five-Year Review, MSTS and AAOS submitted 14 soft tissue tumor codes and 12 bone tumor codes which were ultimately referred again to the CPT Editorial Panel for clarification and creation of new codes to differentiate the codes based on the size and depth of the tumor. In February 2009, the CPT Editorial Panel approved the coding proposal submitted by the Soft Tissue Tumor and Bone Workgroup which revised and expanded the soft tissue tumor and bone tumor sections to more accurately describe the services being provided and address the concerns raised by the RUC during the Third Five-Year Review.

Subcutaneous Excision of Soft Tissue Tumor Codes
There are currently 10 CPT codes that describe subcutaneous excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes differentiated by the size of the excised lesion. These codes were never part of a Five-Year Review Process, however, the societies agreed that these codes needed to consistent with the new coding convention of the subfascial and radical soft tumor excision codes. Between 75-150 general surgeons, otolaryngologists, orthopaedic surgeons, general and orthopaedic surgical oncologists, hand surgeons, plastic surgeons, foot and ankle orthopaedic surgeons, and podiatrists participated in the some or all of the surveys. All of the specialty societies met several time by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked. In addition to this analysis, the specialty societies noted that because these codes were never part of a Five-Year Review Process, they recommended and the RUC agreed that the recommendations for this family of codes should be work neutral. To account for this decision, the specialty societies reduced their recommendations by 2.88%.

Subfascial Excision of Soft Tissue Tumor Codes
There are currently 10 CPT codes that describe subfascial excision of soft tissue tumors. For CPT 2010, these 10 codes have been split into 20 codes differentiated by size of excised lesion. Nine of

these 10 original codes were part of one or more Five-Year Review Processes. The single code not originally identified has very low volume. The RUC sympathized with the argument that there should be work valuation changes but requested that codes first be reviewed by the CPT Editorial Panel. Between 75-150 general surgeons, orthopaedic surgeons, general and orthopaedic surgical oncologists, foot and ankle surgeons, podiatrists, otolaryngologists, hand surgeons and plastic surgeons participated in some or all of the surveys. All of the specialty societies met several times by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked.. In addition to this analysis, the societies noted that 18 of the 20 codes were part of a previous Five-Year Review. The societies presented significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence includes: 1.) Evidence that incorrect assumptions were made in the previous valuation of the service because the Harvard review of these codes did not survey all of the specialties, especially the primary providers, who currently perform these services; and 2.) evidence that technology has changed the physician work because over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Based on this compelling evidence and so not to create rank order anomalies, the RUC agreed that the recommendations for the subfascial excision of soft tissue tumor codes did not have to be work neutral. The RUC reviewed the site of service for this family of codes and agreed with the specialty societies data which supported an overnight hospital stay for seven of the large subfascial codes and three of the small subfascial codes. However, to ensure proper rank order across all of the soft tissue tumor codes, the small subfascial excision of soft tissue tumor codes were reduced by 2.88%. Additionally, the RUC recommended significant decreases to the specialty societies' recommendations for the large subfascial tissue tumor codes to ensure proper rank order with the small subfascial excision services, as a primary difference between the small and large subfascial tumor codes was the difference in the intra-service time. The RUC agrees that this adjustment to the large subfascial tissue tumor codes accounts for the 2.88% reduction and maintains the appropriate relativity to the rest of the tumor excision codes.

Radical Excision of Soft Tissue Tumor Codes

There are currently 11 codes that describe radical excision of soft tissue tumors. For CPT 2010, these 11 codes have been split into 22 codes differentiated by size of excised lesion. Six of these 11 codes were part of one or more Five-Year Review Processes. The RUC sympathized with the argument that there should be work valuation changes but requested that codes first be reviewed by the CPT Editorial Panel. The other five codes have very low volume and are either not performed or rarely performed by orthopaedic surgeons and thus were not included in their comment letters to CMS during the Five-Year Reviews. Between 100-120 general surgeons, otolaryngologists, plastic surgeons, orthopaedic surgeons, orthopaedic and surgical oncologists participated in some or all of the surveys. All of the specialty societies met several times by conference call to discuss the survey statistics. During this review, the societies indicated that they discussed the survey results noting similarities and differences in type of anesthesia positioning, intra-operative time and follow-up care. Several of the codes had exactly the same components which resulted in a recommendation for the same RVU. The specialty societies also indicated that the recommended work RVUs for these codes were correctly ranked. Further, the societies presented and the RUC agreed that there is significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence includes: 1.) Evidence that incorrect assumptions were made in the previous valuation of the service because the Harvard review of these codes did not survey all of the specialties who currently perform these services and 2.) Evidence that technology has changed the

physician work because over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Further, for malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This advancement has allowed for increased ability to kill tumors in situ at a higher level. These tumors are typically asymptomatic and therefore attain large size before being excised. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels. Based on this compelling evidence and so not to create rank order anomalies, the RUC agreed that the recommendations for the radical excision of soft tissue tumor codes did not have to be work neutral. However, to ensure proper rank order across all of the soft tissue tumor codes, the radical excision of soft tissue tumor codes were reduced by 2.88%.

New Codes for Excision of Soft Tissue Tumor Codes
In addition to these revisions to the existing code set, the CPT Editorial Panel created 4 new subcutaneous, 4 new subfascial and 2 new radical excision codes. These codes were created to fill in anatomic gaps in the coding convention for excision of soft tissue tumors. The specialty societies noted that CPT Assistant indicated excision of subcutaneous soft tissue tumors may be reported with benign or malignant lesion codes which have a 10 day global period or an unlisted services code. The specialty societies also noted that excision of deep subfascial tumors or radical soft tissue excision procedures would currently be reported with the unlisted code. However, to ensure proper rank order across all of the soft tissue tumor codes, these new excision of soft tissue tumor codes were reduced by 2.88%. In addition to this reduction, the RUC determined that further reductions should be made to two of the four new subfascial codes to keep in rank order with the recommendations from the other subfascial codes.

Frequency and Impact
The specialties had difficulty in estimating the frequency split for current codes and frequency estimates for new codes but made a best faith effort. The specialties stated that they made several assumptions given the fact that this section has been completely revised including new guidelines and instructions. The RUC appreciated the difficulty of this task and agreed with the specialties recommended utilization. **However, the RUC recommended that these services should be re-reviewed to determine the accuracy of these utilization assumption in three years at the September 2012 RUC meeting to allow for time to obtain two years of frequency data from Medicare (2010 and 2011).** The overall increased work impact of the RUC recommendations for these services, given the society recommended utilization assumptions, is minor.

Repairs Resulting from Excisions
The RUC discussed the issue of separately reporting complex wound repair when performing an excision of a tumor, as the current introductory language states including simple or intermediate repair is included. The representatives from American Academy of Orthopaedic Surgeons (AAOS) stated that they have a coding program called *Code X* and it instructs its users about the intra-operative services included in the global service package for specific codes and lists the CCI edits associated with these codes as well. When reviewing how these procedures were originally reported, *Code X* says that either there are currently CCI edits in place which do not allow closure of wound and repair of tissues provided for surgical exposure -12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less*, which is the first code for a simple repair through 13153 *Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)*, which is the last code for a complex repair to be billed separately and/or instructs the user that CPT codes 12001-13153 are included in the global service package when performing these procedures. Therefore, the AAOS states and the RUC agrees that simple,

intermediate and even complex wound closures by these instructions and the CCI edits are considered to be an integral part of the operation for resecting the tumor and are not to be reported separately. The RUC recommends that the introductory language for these codes be modified to reflect this coding convention.

Staff Note: At the February 2009 RUC Meeting, during the presentation of the Excision of Soft Tissue Tumors, a RUC member posed a question to the sponsoring specialty societies regarding complex closures. The following is a transcript of that discussion:

36:57

Siegel: Vignettes state that medial or lateral flaps are made but the intro language states that simple or intermediate repair is included. Is the assumption that a separate flap, a 14000 procedure is being billed for the repair on these

Presenter(Heiner): No, when I wrote the vignettes I had no idea that people would think that it was a separate thing, you know b/c I tried to make it fairly simple there shouldn't be any additional… it should be a simple opening. So, there shouldn't be any complex closure associated with any of these.

Siegel So, can we make an editorial change that states that the repair for the most part is usually included b/ I see this as a loop hole for separate repairs being built with these

Presenter: That is totally a reasonable suggestion

45:12

Hollmann: On the repairs, the codes all have in the introduction, simple and intermediate repairs are inclusive in the procedures so one would expect that there would be CCI edits probably on that anyway. You were only referring to those types of repairs not complex repairs or any reconstructive things?

Siegel: My concern is that the descriptors it seems that one could do complex repairs or flaps or a variety of creative repairs and the reality is that the subcutaneous tumors one cuts down to the lesion, dissects….as Bill and I both know… you cut out.. you don' t have very much of a defect there, its not a very difficult or complex repair at all but the phraseology sets it up that someone would see this vignette and argue that you have created a flap and you can see someone worrying that someone would game the system and essentially taking up more RVUs unnecessarily in a way that would not be appropriate…just trying to stop that before it happens

Hollmann: I wouldn't anticipate CPT putting in language that complex repairs or flap repairs etc, are not allowed to be coded, b/c generally speaking CPT does not get into medical necessity or gaming. We specifically made a point that intermediate and simple repairs are included in all of these things but other things were separately reportable, so I think if there is something very unique about a specific site where one would never clinically see it happening and you want

language..that is something I would need to know because this is not covered in the current language and was not discussed by the Workgroup or CPT.

Siegel: Essentially when you are taking out a subcutaneous lesion, the lesion has acted as a tissue expander, so you have loose skin to work with there..so your repair is often easier than after you had excised skin and it is often a much simpler repair. So something along the lines as repair is not payable separately for this procedure.

49:40

Presenter: Speaking to separately reporting the complex wound closure at the time of excision of the lesion. The Academy has a coding program called *Code X* and it lists the procedures which it considers to be integral to the procedure and which can be reported separately. If you look at the historical code for this, picking the hand one, the excision of a subcutaneous lesion, it says closure of wound and repair of tissues provided for surgical exposure -12001, which is the first code for a simple repair and it goes all the way up to 13153 which is the last code for a complex repair, so it is the Academy's position that even a complex wound closure by its definition in CPT is considered to be an integral part of the operation for resecting the tumor and is not to be reported separately.

Upon further review of the AAOS product, AMA staff learned that *Code X* instructs its users about the intra-operative services included in the global service package for specific codes and lists the CCI edits associated with these codes as well. When reviewing how these procedures were originally reported, *Code X* states that either there are currently CCI edits in place which do not allow closure of wound and repair of tissues provided for surgical exposure -12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less*, which is the first code for a simple repair through 13153 *Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)*, which is the last code for a complex repair to be billed separately and/or instructs the user that CPT codes 12001-13153 are included in the global service package when performing these procedures.

Therefore, based on the information given by the presenters, the RUC recommended that the introductory language for the soft tissue tumor and bone codes include language that simple, intermediate and complex wound repair are considered to be an integral part of the operation for resecting the tumor and are not to be reported separately.

<u>CPT/RUC Discussion Following February 2009 RUC Meeting:</u>
This recommendation was brought to the CPT Executive Committee during their February 2009 Meeting. The CPT Executive Committee agreed with the RUC recommendations, however, when the issue was discussed at the CPT Editorial Panel Meeting, several concerns were raised by the specialties. The Panel requested that this recommendation be referred to the specialties who sponsored this coding change to gain their input and this input would be reported back to the CPT Executive Committee. These specialties agreed that complex repair should be reported separately for the soft tissue and bone tumor codes and thus disagree with the RUC and the presenter's recommendation. Further, the specialties, in their review of the

minutes, requested that the Repairs Resulting from Excision paragraph listed above be removed.

In response to this request selected members of the soft tissue workgroup who had responded to a ballot as requested by the CPT Panel and the Panel representative to the RUC met by teleconference. Panel member Bradford Henley MD indicated that AAOS has undertaken a project to review Code X guidance. AAOS has removed complex repairs from procedures as AAOS indicated complex repairs are generally separately reportable, whether or not CCI edits may exist. The conferees agreed that the intent of the original submission was to allow complex repairs and that as a general rule for procedures, complex repairs, but not simple or intermediate repairs, are separately reported when performed in conjunction with excisions and incisions. The group felt that the point of concern was a potential failure to distinguish between elevating skin flaps to access the tumor (not a complex repair) and extensive undermining required to primarily close a defect after the excision of significant skin. Additionally, it was felt that complex repair would be very infrequent (never typical) and when required may involve a different surgeon in a significant proportion of times. <u>The conferees recommend that the RUC rescind the request for the additional restrictions of reporting of codes 13100-13153 and that CPT insert clarifying introductory language.</u>

Based on this recommendation, AMA Staff proposes the following paragraph to replace the current "Repairs Resulting from Excisions" paragraph:

Repairs Resulting from Excisions
The RUC discussed the issue of separately reporting complex wound repair when performing an excision of a tumor, as the current introductory language states including simple or intermediate repair is included. RUC members expressed concern about complex repair being reported separately with these procedures. After much deliberation, it was determined that these services would rarely require complex repair as defined in CPT codes 13100-13153. However, to alleviate the concern, the CPT Editorial Panel has been requested to add introductory language to this section of codes clarifying the components of complex repair and when it should be reported separately.

The RUC approved this proposal as submitted by AMA Staff and recommends that this aforementioned language be added to the recommendation for these codes.

Practice Expense
The RUC extensively discussed of the clinical labor time associated with the services performed in the non-facility setting and reduced the clinical labor time for several services. In addition, the RUC carefully scrutinized the supplies and equipment and made adjustments to reflect treatment to the typical patient. The practice expense inputs recommended by the specialty in the facility setting were also reviewed and modified. The RUC recommends the attached direct practice expense inputs.

The individual recommendations for this issue have been attached to these minutes.

<u>Bone Tumor (Tab 8)</u>
John Heiner, MD and William Creevy, MD, American Academy Orthopaedic Surgeons, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, and

Daniel Nagle, MD, American Society for Surgery of the Hand, Frank Spinosa, DPM, American Podiatric Medical Association

The American Academy of Orthopaedic Surgery (AAOS) and the Musculoskeletal Tumor Society (MSTS) responded to the Centers for Medicare and Medicaid Services' (CMS) Five-Year Review request for comment on misvalued codes in 1995, arguing that the Hsaio survey had misvalued these services. During the course of this first Five-Year Review process, it became evident that coding changes would be necessary prior to revaluing these services. From 1995-2005, MTMS and AAOS drafted CPT proposals to address issues within the soft tissue tumor excision family and bone tumor family codes but these proposals were rejected by the CPT advisors and/or the CPT Editorial Panel. For the 2005 Five-Year Review, MSTS and AAOS submitted 14 soft tissue tumor codes and 12 bone tumor codes which were ultimately referred again to the CPT Editorial Panel for clarification and creation of new codes to differentiate the codes based on the size and depth of the tumor. In February 2009, the CPT Editorial Panel approved the coding proposal submitted by the Soft Tissue Tumor and Bone Workgroup which revised and expanded the soft tissue tumor and bone tumor sections to more accurately describe the services being provided and address the concerns raised by the RUC during the Third Five-Year Review.

There are currently 20 codes that describe bone tumor codes. All of these codes were part of the one or more Five-Year Review processes. Between 60-100 musculoskeletal orthopaedic surgeons and orthopaedic surgeons, hand surgeons, podiatrists and foot and ankle surgeons participated in all or some of the surveys. After the results of these providers were tabulated, the associated specialty societies met to discuss the data. The societies presented and the RUC agreed that there is significant compelling evidence as to why these recommendations should not be work neutral. This compelling evidence is that there is evidence that technology has changed the physician work as over the past 10 years significant advances have been made which allow for greater imaging and thus more precise understanding of anatomic location and extent of tissue involvement. Further, for malignant tumors, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This advancement has allowed for increased ability to eradicate tumors in situ at a higher level. While 20 years ago amputation was used most commonly to treat these patients, limb preservation resections have now become the standard treatment of care as currently less than 5% of patients with pelvic and extremity sarcomas receiving amputations. The specialty society argued and the RUC agrees that the work associated with soft tissue resection procedures has increased dramatically as these procedures are now more technically demanding, prolonged and involve additional risk.

Pelvis

The RUC reviewed the specialty societies' survey results for the eight pelvis radical resection of tumor codes. The specialty societies indicated and the RUC agreed that 10 years ago patients would undergo total leg amputation in cases of bone sarcomas of the pelvis, whereas now limb salvage is an option. The typical pelvis radical resection of tumor patient is usually in the hospital for 7-10 days.

27077

The RUC reviewed the pelvis anchor codes starting with the largest, most complex procedure of this family, code 27077 *Radical resection of tumor; innominate bone, total*. The RUC reviewed the pre-service time and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral

position after anesthesia is administered. The RUC compared 27077 to key reference service 20956 *Bone graft with microvascular anastomosis; iliac crest* (work RVU = 40.93, intraservice time 400 minutes) and determined that the survey median physician time of 400 minutes and work RVU of 45.00 appropriately accounted for the physician time and work required to perform this service and placed this service in the proper rank order. The RUC noted that the survey respondents indicated that 27077 was much more intense than 20956. The RUC further supported a work RVU of 45.00 for 27077 by comparing it to similar service, 20973 *Free osteocutaneous flap with microvascular anastomosis; great toe with web space* (work RVU = 46.95).

The specialty society indicated and the RUC agreed that four 99231 and four 99232 hospital visits are typical as patients are usually in the hospital for 7-10 days and since limb salvage is possible the patient will need that time to recover in the hospital. The specialty society also indicated and the RUC agreed that one higher level office visit, 99214, was appropriate as the physician will perform an extensive consultation, review of pathology margins, contact 2-3 consulting physicians, oncologists or radiation oncologists and the visit will last one hour to 1.5 hours. Patients typically have sarcomas and aggressive cancer and a 99214 allows for extensive treatment plans. Additionally the RUC determined that 2-99213 office visits are appropriate because typically these extremity related events require significant physical therapy, joint stability examination and range of motion checks. **The RUC recommends the survey median work RVU of 45.00 for code 27077.**

27076

The RUC reviewed code 27076 *Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum* and agreed with the specialty societies that there has been a long standing rank order anomaly between codes 27076 and 27077 (approximately 22.00 difference in RVUs). The RUC reviewed the pre-time and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC determined that 27076 required slightly less physician intra-service time than 27077 (360 versus 400, respectively). However, 27076 is slightly more intense than 27077 because of the location and size of large the tumors typically surrounding the areas of the pelvis being removed in this procedure. The RUC compared code 27076 to 27077 and key reference service 20956 *Bone graft with microvascular anastomosis; iliac crest* (work RVU = 40.93, intraservice time 400 minutes). The RUC noted that they survey respondents indicated that 27076 is more intense and complex than 20956. Even though the intra-service time is longer for reference service 20956, more mental effort, technical skill and psychological stress is exerted or occurs when performing 27076. The RUC determined that the survey median physician time of 360 minutes and work RVU of 40.00 appropriately accounted for the physician time and work required to perform this service and placed this service in the proper rank order. The RUC agreed with the specialty society and recommends one less 99231 hospital visit for 27076 than 27077. **The RUC recommends the survey median work RVU of 40.00 for 27076.**

27075

The RUC reviewed code 27075 *Radical resection of tumor; wing of ilium, one pubic or ischial ramus or symphysis pubis* and determined that the physician time and work required will be significantly less than 27076 and 27077 as this procedure is the removal of one portion of the pelvis. Additionally, 27075 requires fewer hospital visits (2-99231 and 3-99232 visits) than 27076 and 27077. The RUC reviewed the pre-time and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must

conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as the typically the patient is in the supine position for this procedure. The RUC compared code 27075 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time required to perform 27075 is slightly more than 270134. The survey respondents also responded that 27075 is more intense and complex than 27134. The RUC determined that a work RVU of 32.50 for 27075 appropriately places this service in the proper rank order within this family of services. **The RUC recommends the survey median work RVU of 32.50 for 27075.**

27078
The RUC reviewed 27078 *Radical resection of tumor; ischial tuberosity and greater trochanter of femur* and determined that the physician time, work and intensity required is similar to 27075. The RUC reviewed the pre-time and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordinate with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone position after anesthesia is administered. The RUC compared code 27078 to 27075 and to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician intra-service time required to perform these services is the same and the physician work and intensity required is similar. Additionally, 27078 requires the same number of hospital and office visits as 27075. **The RUC recommends the survey median work RVU of 32.00 for 27078.**

Upper Limb
The RUC reviewed the upper limb radical resection of tumor codes. The specialty societies indicated that most patients receiving these procedures have had pre-operative chemotherapy and are catabolic and may have sarcomas pressing on the aortic arch and subclavian. The physician must carefully identify the soft tissue mass as not to damage surrounding viable tissue. Thus, the closer the tumor is to the shoulder the more complex the procedure. The specialty societies indicated that one 99214 office visit is required for each upper limb radical resection of bone tumor codes. The RUC agreed that the number of office visits were appropriate as the physician will discuss pathology, coordinate care, and assess functional rehabilitation and physical therapy.

23200
The RUC reviewed the pre-service time for code 23200 *Radical resection of tumor; clavicle* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the lateral position. The RUC then compared 23200 to key reference service 27447 Arthroplasty, *knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)* (work RVU = 23.04, intra-service time = 124 minutes) and determined that the physician time and intensity was slightly higher for code 23200. The RUC determined the survey median work RVU of 22.50 and median physician time of 155 minutes appropriately places this service in the proper rank order within this family of services. **The RUC recommends the survey median work RVU 22.50 for 23200.**

23210

The RUC reviewed the pre-service time for code 23210 *Radical resection of tumor; scapula* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone or lateral position. The RUC then compared 23210 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time, work and intensity was slightly lower for code 23210. The RUC noted that the 23210 has a slightly lower work RVU than 27134, as it has a shorter length of stay requiring only one 99231. The RUC determined the survey 25th percentile work RVU of 27.00 and median intra-service time of 210 minutes appropriately placed 23210 in relativity to 27134. **The RUC recommends the survey 25th percentile work RVU of 27.00 for 23210.**

23220

The RUC reviewed the pre-service time for code 23220 *Radical resection of tumor; proximal humerus* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the lateral position. The RUC then compared 23220 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time, work and intensity was the same for these procedures. The RUC determined the survey 25th percentile work RVU of 30.00 and median physician time of 240 minutes was appropriate to perform this service. **The RUC recommends the survey 25th percentile work RVU of 30.00 for 23220.**

24150

The RUC reviewed the pre-service time for code 24150 *Radical resection of tumor; shaft or distal humerus* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and position the arm and hand correctly. The RUC then compared 24150 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity was the similar for these procedures. The RUC agreed that the survey median work RVU of 23.25 and median physician time of 180 minutes was appropriate to perform this service. **The RUC recommends the survey median work RVU of 23.25 for 24150.**

24152

The RUC reviewed the pre-service time for code 24152 *Radical resection of tumor; radial head or neck* and agreed with the specialty society that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 24152 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity was the similar for these procedures. The RUC determined the survey 25th percentile work RVU of 19.78 and median physician time of 150 minutes was appropriate to

perform this service. **The RUC recommends the survey 25th percentile work RVU of 19.78 for 24152.**

25170
The RUC reviewed the pre-service time for code 24170 *Radical resection of tumor; radius or ulna* and agreed with the specialty society that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 24170 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU = 22.47, intra-service time = 150 minutes) and determined that the physician time, work and intensity is similar for these procedures. The RUC agreed the survey median work RVU of 22.00 and similar total physician time indicates that the work for these two services are the same. **The RUC recommends the survey median work RVU of 22.00 for 25170.**

26250
The RUC reviewed the pre-service time for code 26250 *Radical resection of tumor; metacarpal* and agreed with the specialty society that pre-time package 2b – Difficult Patient/Straightforward Procedure was appropriate. The specialty society indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 10 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 26250 to key reference service 25447 *Arthroplasty, interposition, intercarpal or carpometacarpal joints* (work RVU = 10.95, intra-service time = 100 minutes) and determined that the physician time, work and intensity is higher for 26250. To further support the survey median work RVU of 15.00, the RUC compared 26250 to 24346 *Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)* (work RVU = 14.97, intra-service time = 120 minutes), which requires similar physician work and intra-service time. The RUC determined the survey median work RVU of 15.00 and median physician time of 120 minutes was appropriate to perform this service. **The RUC recommends the survey median work RVU of 15.00 for 26250.**

26260
The RUC reviewed the pre-service time for code 26260 *Radical resection of tumor; proximal or middle phalanx of finger* and agreed with the specialty society that pre-time package 2b – Difficult Patient/Straightforward Procedure was appropriate. The specialty society indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 10 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC then compared 26260 to key reference service 25447 *Arthroplasty, interposition, intercarpal or carpometacarpal joints* (work RVU = 10.95, intra-service time = 100 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey 25th percentile work RVU of 11.00 and median physician time of 90 minutes was appropriate to perform this service. **The RUC recommends the survey 25th percentile work RVU 11.00 for 26260.**

26262

The RUC reviewed the pre-service time for code 26262 *Radical resection of tumor; distal phalanx of finger* and agreed with the specialty society that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The specialty society indicated and the RUC agreed that the survey respondents slightly overestimated the pre-service evaluation time and that time is actually captured in the scrub, dress, and wait time. Therefore, the RUC removed 5 minutes of pre-evaluation time from the established package and added it to the scrub, dress, wait pre-time. The RUC determined that an additional 9 minutes of pre-positioning time is required to place the patient in the supine position and adjust the arm and hand for a clear operative site. The RUC agreed that in cases with a malignant bone tumor of the finger, it is usually amputated, but in some cases the thumb may be preserved. The RUC then compared 26262 to key reference service 24685 *Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed* (work RVU = 8.21, intra-service time = 60 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC compared 26262 to code 28175 *Radical resection of tumor; phalanx of the toe* and to avoid a rank order anomaly the RUC agreed that the 25th percentile work RVU for of 8.13 for 28175 is appropriate for 26262 as it is similar to the survey 25th percentile work RVU of 8.00. The RUC determined that a work RVU of 8.13 and physician time of 60 minutes is appropriate to perform the work required for this procedure. **The RUC recommends a work RVU of 8.13 for 26262**.

Lower Limb

The RUC reviewed the specialty societies' survey results for the lower limb radical resection of tumor codes. The specialty societies indicated now, as opposed to 10 years ago, most patients will receive a total femoral replacement instead of amputation. The typical Medicare patient population may have more metastatic disease of the distal femur or renal cell carcinoma. Patients are typically in the hospital for a week. The lower limb radical resection procedures have similar intensity to the pelvis iliac wing resection, code 27075, but are not as high as the total pelvis resection or pelvis and acetabulum resections 27077 or 27076. The specialty societies indicated that one 99214 office visit is required for each lower limb radical resection of bone tumor codes. The RUC agreed that the number of office visits were appropriate as the physician will discuss pathology, coordinate care, and assess functional rehabilitation and physical therapy.

27365

The RUC reviewed the pre-service time for code 27365 *Radical resection of tumor; femur or knee* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as typically the patient is in the supine position for this procedure. The RUC then compared code 27365 to key reference service 27134 *Revision of total hip arthroplasty; both components, with or without autograft or allograft* (work RVU = 30.13, intra-service time = 240 minutes) and determined that the physician time required to perform these services is exactly the same and the work required is slightly more intense for 27365. Additionally, the RUC compared 27365 to 27078 and agreed these services are similar, both requiring the same intra-operative time of 240 minutes. However, 27365 is slightly more intense intra-operatively because for this procedure the physician typically must carefully isolate and immobilize the popliteal and femoral arteries. Additionally, 27365 requires the same number of hospital and office visits as 27078. **The RUC recommends the survey median work RVU of 32.00 for 27365**.

27645

The RUC reviewed code 27645 *Radical resection of tumor; tibia* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the

physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. No additional positioning time is required as the typically the patient is in the supine position for this procedure. The RUC then compared code 27645 to key reference service 27156 *Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip* (work RVU = 26.03, intra-service time = 225 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey median work RVU of 27.00 and median physician time of 200 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends a work RVU of 27.00 for 27645.**

27646
The RUC reviewed 27646 *Radical resection of tumor; fibula* and agreed with the specialty society that pre-time package 4 – Difficult Patient/Difficult Procedure was appropriate, as the physician must conduct an additional extensive review of the pathology studies, coordination with radiation therapy, etc. The RUC determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC then compared code 27646 to key reference service 27447 Arthroplasty, *knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)* (work RVU = 23.04, intra-service time = 124 minutes) and determined that the physician time, work and intensity is similar for these services. The RUC determined the survey median and 25th percentile work RVU of 23.00 and median physician time of 180 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends the survey median work RVU of 23.00 for 27646.**

27647
The RUC reviewed code 27647 *Radical resection of tumor; talus or calcaneus* and agreed with the specialty society that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 10 minutes of pre-evaluation time was appropriate for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with the reconstructive surgeon. The RUC also determined that an additional 17 minutes of pre-positioning time is required to place the patient in the prone position after anesthesia is administered. The RUC then compared code 27647 to key reference service 27580 *Arthrodesis, knee, any technique* (work RVU = 20.90, intra-service time = 150 minutes) and determined the physician time, work and intensity is similar for these services. The RUC determined the survey median work RVU of 20.10 and median physician time of 144 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. **The RUC recommends the survey median work RVU of 20.10 for 27647.**

28171
The RUC reviewed code 28171 *Radical resection of tumor; tarsal (except talus or calcaneus)* and agreed with the specialty society that pre-time package 3 – Straightforward Patient/Difficult Procedure was appropriate. The RUC determined that an additional 10 minutes of pre-evaluation time was appropriate for extensive additional review of imaging and pathology studies to correctly mark and plan the procedure and consultation with the reconstructive surgeon. The RUC also determined that an additional 17 minutes of pre-positioning time is required to place the patient in the lateral position after anesthesia is administered. The RUC then compared code 28171 to key reference service 27580 *Arthrodesis, knee, any technique* (work RVU = 20.90, intra-service time = 150 minutes) and determined the physician time, work and intensity is slightly lower for 28171. To further support the survey 25th percentile work RVU of 16.25, the

RUC compared 28171 to 28415 *Open treatment of calcaneal fracture, includes internal fixation, when performed* (work RVU = 15.96, intra-service time = 120 minutes), which requires similar physician work and intra-service time. The RUC determined the survey 25th percentile work RVU of 16.25 and median physician time of 120 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services and reference service. **The RUC recommends the survey 25th percentile work RVU of 16.25 for 28171.**

28173
The RUC reviewed code 28173 *Radical resection of tumor; metatarsal* and agreed with the specialty society that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The RUC determined that an additional 2 minutes of pre-positioning time is required to elevate the patient's leg, stabilize the foot and pad the opposite extremity. The RUC then compared code 28173 to key reference service 28715 *Arthrodesis; triple* (work RVU = 14.40 intra-service time = 130 minutes) and determined the physician time, work and intensity is similar for these services. The RUC determined the survey 25th percentile work RVU of 14.00 and median physician time of 110 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services and reference service. **The RUC recommends the survey 25th percentile work RVU of 14.00 for 28173.**

28175
The RUC reviewed code 28175 *Radical resection of tumor; phalanx of toe* and agreed with the specialty society that pre-time package 1b – Straightforward Patient/Straightforward Procedure was appropriate. The RUC determined that an additional 2 minutes of pre-positioning time is required to elevate the patient's leg and stabilize the foot. The RUC then compared code 28175 to key reference service 29891 *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47 intra-service time = 60 minutes) and determined the physician time, work and intensity is similar for these services. To further support the survey 25th percentile work RVU of 8.13, the RUC compared 28175 to 24685 *Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]), includes internal fixation, when performed* (work RVU = 8.21, intra-service time = 60 minutes), which requires similar physician work and intra-service time. The RUC determined the survey 25th percentile work RVU of 8.13 and median physician time of 60 minutes appropriately places this procedure in the proper rank order with the other lower limb radical tumor resection services. Additionally, the RUC agreed that upper limb radical resection of bone tumor code 26262 is equal to this lower limb resection of bone tumor code 28175. **The RUC recommends the survey 25th percentile work RVU of 8.13 for 28175.**

Practice Expense
The practice expense inputs recommended by the specialty in the facility setting were reviewed and agreed upon. **The RUC recommends the attached standard 090-day direct practice expense inputs.**

<u>Navigational Bronchoscopy (Tab 9)</u>
Scott Manaker, MD, PhD, American College of Chest Physicians and Alan Plummer, MD American Thoracic Society

In October 2008 the CPT Editorial Panel created a new add-on code to describe the pre-planning, real time navigation of the bronchus or placement of fiducial markers.

The RUC reviewed the specialty society recommendation for 316X1 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with computer-assisted, image-guided navigation* and agreed with the physician time and work presented and supported by the survey median (60 minutes intra-service time and work RVU = 2.00). The RUC agreed that the physician work required for planning/mapping, downloading CT information and registering information typically would take 30 minutes and the actual performance of directional bronchoscopy would take an additional 30 minutes. The RUC compared 316X1 to 31637 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; each additional major bronchus stented* (work RVU = 1.58, intra-service time = 30) and determined this supported the physician time and work required to perform 316X1 as 31637 does not include an additional 30 minutes of planning and mapping. **The RUC recommends a work RVU of 2.00 for code 316X1.**

Practice Expense
The RUC recommends the specialty society recommended practice expense inputs for the non-facility setting as attached.

New Technology
The RUC recommends that code 316X1 be placed on the new technology list for future review.

Modifier -51 Exempt
The RUC recommends that code 316X1 be placed on the Modifier-51 Exempt list as this procedure is typically performed with another procedure. The RUC recommended value is based on its Modifier -51 exempt status.

Moderate Sedation
The RUC recommends that 316X1 be added to the Moderate Sedation List.

Laparoscopic Paraesophageal Hernia Repair (Tab 10)
American College of Surgeons and Society of American Gastrointestinal and Endoscopic Surgeons

The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) requested to defer RUC review of this issue until April 2009 after the CPT Editorial Panel clarifies SAGES October 2008 request to develop two new codes instead of one code to describe this laparoscopic paraesophageal hernia repair. The CPT Editorial Panel will review this issue at its February 2009 meeting.

Rectal Tumor Excision (Tab 11)
Christopher Senkowski, MD, American College of Surgeons and Guy Orangio, MD, American Society of Colon and Rectal Surgeons

CPT code 45170, *Excision of tumor, transanal approach* was identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. Code 451X2 was also identified in the High IWPUT screen and discussed by the RUC at its February 2008

meeting. The RUC recommended that the service be referred to CPT because the current descriptor allowed reporting of the code to a bi-modal distribution of patients. In October 2008, the CPT Editorial Panel deleted 45170 (work RVU = 12.48) and replaced it with two new Category I codes to provide greater granularity, 451X1, *Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)* and 451X2, *Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness).*

451X1
The specialty society presented the survey data from 92 general and colorectal surgeons. The RUC reviewed the intra-service physician time and noted that the median time of 45 minutes was appropriate. The specialty indicated that this service would typically be provided on an outpatient basis. The RUC agreed with the specialty society that the pre-service time package should be package #3, straightforward patient/difficult procedure, as this time most accurately reflects the work performed. However, the RUC did not agree with the specialty that 20 minutes of positioning time was correct. Survey respondents indicated that 15 minutes were necessary. Therefore, the RUC adjusted the pre-service positioning time from the 3 minutes within package #3 to 15 minutes, rather than the 20 minutes recommended by the specialty. The RUC then reviewed the survey RVU and agreed with the specialty society that the survey 25th percentile work recommendation of 8.00 was appropriate. The RUC considered the surveyed code in comparison to the key reference service, 45190, *Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach* (work RVU = 10.29). The RUC noted that despite similar intensity and complexity measurements between the surveyed code and the key reference code, the reference code requires 15 additional minutes of intra-service time (60 minutes and 45 minutes, respectively). Based on this comparison, the RUC agreed that the survey 25th percentile work RVU of 8.00 was appropriate. **The RUC recommends the survey 25th percentile RVU of 8.00 for 451X1.**

451X2
The specialty society presented the survey data from 92 general and colorectal surgeons. The RUC reviewed the intra-service physician time and noted that the median time of 75 minutes was appropriate. The RUC agreed with the specialty society that the pre-service time package should be package #4, difficult patient/difficult procedure, as this time most accurately reflects the work performed. However, the RUC did not agree with the specialty that 20 minutes of positioning time was correct. Survey respondents indicated that 15 were necessary. Therefore, the RUC adjusted the pre-service positioning time from the 3 minutes within package #4 to 15 minutes, rather than the 20 minutes recommended by the specialty. The RUC then reviewed the survey RVU and agreed with the specialty society that the survey median work RVU of 12.00 was appropriate. The RUC considered the surveyed code in comparison to the key reference service, 45190, *Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach* (work RVU = 10.29). The RUC noted that the key reference service requires 15 fewer minutes of intra-service time (60 minutes and 75 minutes, respectively). Code 451X2 also includes a full 99238 discharge day management procedure as well as a 99231 hospital visit within its global period, whereas the reference code does not. The RUC agreed that 451X2 would typically require an inpatient stay. Lastly, the RUC noted that survey respondents indicated 451X2 requires greater mental effort and judgment as well as greater technical skill and physical effort than the reference code. In light of these differences, the RUC agreed that the median work RVU of 12.00 was appropriate. **The RUC recommends the survey median work RVU of 12.00 for 451X2.**

Practice Expense
The RUC recommended the standard 90 day global practice expense inputs.

Temporary Prostatic Urethral Stent Insertion (Tab 12)
James G. Giblin, MD, American Urological Association

At its October 2008 meeting, the CPT Editorial Panel created 5385X, *Insertion of a temporary prostatic urethral stent, including urethral measurement*, a Category I code to describe the work previously reported in Category III code, 0084T, *Insertion of a temporary prostatic urethral stent*, to accurately describe the measurement and insertion of a temporary prostatic stent as a stand alone procedure used as treatment for complications that follow microwave therapy (code 53850, *Transurethral destruction of prostate tissue; by microwave thermotherapy*). Approximately 10% of patients who have microwave therapy may potentially require this procedure or placement of a foley catheter, which is the only present treatment.

The RUC reviewed the survey data from 30 urologists presented by the specialty society. The RUC reviewed the survey physician times and agreed that the median survey intra-service time of 15 minutes is appropriate. The RUC also agreed with the specialty society that pre-service time package 5, non-facility procedure without sedation or anesthesia, is appropriate. The RUC also agreed with the specialty society expert panel that the survey 25th percentile work RVU of 1.64 is appropriate. The RUC compared 5385X to key reference service 53620, *Dilation of urethral stricture by passage of filiform and follower, male; initial* (work RVU = 1.62), which reflects similarities to the time. The RUC concluded that the two services are similar and recommended the survey 25th percentile work RVU of 1.64. **The RUC recommends the survey 25th percentile work RVU of 1.64 for 5385X.**

Modifier 51
The RUC recommends that 5385X not be placed on the modifier -51 exempt list because the procedure is performed within the global period of 53850, *Transurethral destruction of prostate tissue; by microwave thermotherapy*, but never performed with 53850.

Practice Expense
The RUC reviewed the direct practice expense inputs for 5385X and approved the attached inputs.

New Technology
The RUC recommends that 5385X be placed on the New Technology list.

Spinal Neurostimulator Electrode (Tab 13)

The Five-Year Review Identification Workgroup identified code 63660 *Revision or removal of spinal neurostimulator electrode percutaneous array(s) or place/paddle(s)* on its site-of-service anomaly screen, indicating that this service is no longer provided predominantly in the inpatient setting. The RUC recommended that this code be reassigned to a 010-day global period and be resurveyed. However, the multi-specialty expert panel determined that the current descriptor was too broad to be able to define the work. The specialty society requested that the CPT Editorial Panel create separate codes to describe the distinct work involved in the revision and in the removal of a percutaneous electrode when compared to the revision or the removal of a "plate/paddle" electrode array. In October 2008, the CPT Editorial Panel deleted code 63660 and created four new codes to appropriately describe these services.

In November 2008, the specialty societies requested that CMS reconsider the global period assigned to codes 6366X1 and 6366X3 since percutaneous procedures are usually classified as minor

procedures. In December 2008 CMS agreed to assign a 010-day global period to codes 6366X1 and 6366X3. The specialty society will present recommendations at the April 2009 RUC meeting.

Muti-Leaf Collimator IMRT Device Use (Tab 14)
Najeeb Mohideen, MD American Society for Therapeutic Radiology and Oncology

In October 2008 the CPT Editorial Panel created a new code to describe the design and construction of multi-leaf collimator (MLC) intensity modulated radiation therapy (IMRT) device use. Previously, patients treated with IMRT were reported under code 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU = 1.24). However, the technical component expense portion was incorrectly captured in the practice expense of code 77418 *Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*, not under code 77334.

The RUC reviewed 7733X *Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction*. The specialty societies indicated that 7733X captures the appropriate physician work and practice expense, specifically the medical physics and medical dosimetry time and equipment that was not in code 77418. The specialty societies indicated that the physician work starts at the time following treatment plan 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* (work RVU = 7.99). Multiple fluence patterns are generated and the physician must review the plan and make the proper adjustments to the MLC device prior to treatment to protect normal surrounding tissue (i.e., bladder, anterior rectal wall, etc). The physician selects a range set of segments for each device, fine tunes and deletes small segments to eliminate any treatment inefficiency and adjusts the dose profile again for every beam (typically 9 beams). The specialty society indicated and the RUC agreed that the physician work required to adjust each beam is approximately 13 minutes per beam (total intra-service time = 115 minutes). The specialty society indicated that each fluence map is different for every beam so each requires approximately the same amount of time, in other words, each additional beam would not require less time nor would the physician become more efficient.

The specialty society indicated and the RUC agreed that the survey 25th percentile work RVU of 4.29 appropriately accounted for the work required to perform this service. The RUC compared 7733X to reference service 77295 *Therapeutic radiology simulation-aided field setting; 3-dimensional* (work RVU = 4.56 and 98 minutes intra-service time) and determined that although the reference code requires less physician time, it is slightly more intense and complex to perform than 7733X. Additionally, the RUC compared 7733X to the physician work that is currently reported as 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU = 1.24, intra-service time = 35 minutes), which is reported per field. The IWPUT for CPT 77334 (0.035) when compared to the survey physician time for 7733X (115 minutes) supports the survey 25th percentile RVU recommended by the specialty society (0.035 x 115 = 4.03). **The RUC recommends the survey 25th percentile work RVU of 4.29 for code 7733X.**

Practice Expense
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

PLI

The RUC recommends the PLI for 7733X be crosswalked to 77295 *Therapeutic radiology simulation-aided field setting; 3-dimensional* and a 0.00 PLI for the technical component only.

Coronary Computed Tomographic Angiography (Tab 15)
Reviewed by Facilitation Committee #3
James Maloney, MD, American College of Cardiology, and Geraldine McGinty, MD, American College of Radiology

In October 2008 the CPT Editorial Panel deleted eight Category III codes and created four new codes to describe the evolution of performing cardiac and coronary computed tomography for specific clinical scenarios.

7557X1 ***Computed tomography, heart without contrast material, with quantitative evaluation of coronary calcium***
The RUC reviewed the specialty societies' recommended data and agreed that the physician time (5 minutes pre-, 10 minutes intra- and 5 minutes post-service time) recommended by the specialties accurately reflected the service. However, the RUC did not agree that the survey values were reflective of the work performed, noting that even the survey 25th percentile work RVU of 0.70 was too high. The RUC compared 7557X1 to code 75962 *Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation* (work RVU = 0.54 and 12 minutes total physician time) and determined that 7557X1 required slightly more work. The RUC also compared 7557X1 to similar services 95903 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study* (work RVU = 0.60 and 8 minutes pre-, 10 minutes intra- and 10 minutes post-service time) and 11000 *Debridement of extensive eczematous or infected skin; up to 10% of body surface* (work RVU=0.60 and 5 minutes pre-, 10 minutes intra- and 5 minutes post-service time). The RUC determined that a work RVU of 0.58 for 7557X1 appropriately accounts for the work required to perform this service. Additionally, CPT codes 75962, 95903 and 11000 have similar work RVUs and physician time compared to surveyed code 7557X1. **The RUC recommends a work RVU of 0.58 for CPT code 7557X1.**

7557X2 ***Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)***
The specialty society provided a very detailed description of the work included in 7557X2, which includes evaluation of cardiac structure, morphology, venous structures, 3D reconstruction, contrast and administration of a beta-blocker. The RUC agreed with the specialty society that the survey median work RVU of 2.25 is too high, while the survey 25th percentile work RVU of 1.25 does not account for the extent of the work performed. The RUC reviewed several comparable reference services: 72196, *Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)* (work RVU = 1.72, pre-service = 15, intra-service = 20, post-service = 10); 71551, *Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)* (work RVU = 1.73, pre-service = 10, intra-service = 25, post-service = 10); 70498, *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, pre-service = 7, intra-service = 20, post-service = 10); and 70496, *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, pre-service = 8, intra-service = 20, post-service = 10). The RUC agreed that these services are appropriate references and a work RVU of 1.75, which is half way between the survey 25th percentile and median, maintains rank order within this family of services. **The RUC recommends a work RVU of 1.75 for 7557X2.**

7557X3 ***Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)***
The RUC reviewed the pre-service time for 7557X3 and agreed with the societies' recommended additional pre-service time compared to the other services within this family, as the physician has several pre-operative tests to review and as the service is typically performed on a child, the physician must answer many questions posed by the patient and the patient's family. The RUC agreed that the service time, 15 minutes of pre-service time, 30 minutes of intra-service time and 15 minutes of post-service time, accurately reflect the service. After reviewing the physician time, the RUC compared the surveyed code to the reference code, 75564 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress* (Work RVU=3.35). As the surveyed code has significantly less total service time as compared to the reference code (60 and 85 minutes, respectively) and the surveyed code is performed on a child rather than an adult as in the reference code, the RUC agreed that a work RVU of 2.55, the surveyed 25th percentile, accurately reflects the work associated with 7557X3. **The RUC recommends a work RVU of 2.55 for 7557X3.**

7557X4 ***Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)***
The RUC reviewed the specialty society physician time and work RVU data recommended data for code 7557X4, 10 minutes pre-service, 30 minutes intra-service and 10 minutes post-service time. The specialty society recommended a lower pre-and post-service time than the surveyed time by reducing 5 minutes from both the pre- and post-service time because the respondents indicated higher times than are typical when compared to similar services. The RUC determined that 30 minutes of intra-service time, as indicated by the survey respondents, was appropriate to account for the time required to perform this service (issue multiple beta blockers, contrast media two times, calculate fractions, calculate cardiac output, etc). The RUC then compared 7557X4 to code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material* (work RVU = 2.35, 10 minutes pre-time, 40 minutes intra-time and 10 minutes post-time) plus 96375 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug* (work RVU = 0.10) (2.35 + 0.10 = 2.45) to support a work RVU of 2.40 for code 7557X4, which is less than the survey 25th percentile. **The RUC recommends a work RVU of 2.40 and 10 minutes pre-, 30 minutes intra- and 10 minutes immediate post-service time for code 7557X4.**

Practice Expense
The RUC reviewed the practice expense inputs for all four services within the family and confirmed the clinical labor time proposed by the Practice Expense Subcommittee. The RUC discussed the equipment and recommends that the uninterruptible power supply be deleted as it is an indirect expense. The tilt table was also deleted from equipment. The RUC reviewed the appropriate time that the CT scanner will be in use and recommends the following time (activities = lines 78 and 79):

7557X1, 16 slice CT = 15 minutes
7557X2, 64 slice CT = 26 minutes
7557X3, 64 slice CT = 37 minutes

7557X4, 64 slice CT = 43 minutes

The computer workstation and all software are equal to (line 88 - reconstruct images at selected intervals…)

7557X1 = 12 minutes
7557X2 = 21 minutes
7557X3 = 23 minutes
7557X4 = 29 minutes

New Technology
The RUC recommends that these services be added to the New Technology List.

PLI Codes
The RUC recommends the PLI for the technical component of each service be 0.00. The RUC recommends following PLI crosswalks:

7557X1 should be crosswalked to 78472
7557X2 should be crosswalked to 70498
7557X3 should be crosswalked to 75558
7557X4 should be crosswalked to 75557

Myocardial Perfusion Imaging (Tab 16)
Reviewed by Facilitation Committee #3
James Maloney, MD, American College of Cardiology, and Geraldine McGinty, MD, American College of Radiology Gary Dillehey, MD and Kenneth McKusick, MD, Society of Nuclear Medicine/American College of Nuclear Physicians

The RUC identified 78465, 78478, and 78480 as potentially misvalued through its Codes Frequently Reported Together screening mechanism, as combinations of these codes are reported together more than 95% of the time. To address its concerns, the RUC recommended that the services be referred to CPT to create bundled services that accurately describe the work that is typically performed. The CPT Editorial Panel, at its October 2008 meeting, deleted the existing family of myocardial perfusion imaging services (which included 78460, 78461, 78464, 78465, 78478, and 78480) and created four new Category I CPT codes to describe the work. These new codes are 784X1, *Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)*, 784X2, *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*, 784X3, *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic),* and 784X4, *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*

784X2

The RUC discussed CPT code 784X2, which is the most complex code within this family and accounts for the greatest utilization. The specialty society provided a detailed description of the work included within the service. The RUC discussed the survey results and noted that there was an exceptionally high median survey performance rate among the 83 respondents, which adds significant support to the survey data. As such, the RUC agreed that the median survey physician times of 10 minutes pre-service, 20 minutes intra-service, and 10 minutes immediate post-service time accurately reflect the time required to perform this service. However, the RUC agreed that the median survey work RVU of 1.87 was too high and did not accurately reflect the work being performed in the surveyed code. The RUC agreed that the key reference service, 78492, *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress*, was inappropriate because of the wide difference in intra-service time between the survey code and reference code (20 minutes and 55 minutes, respectively). The RUC agreed a better reference code for 784X2 is MPC code 70496, *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, pre-service = 8, intra-service = 20, post-service = 10). The RUC and the specialty society presenters agreed that the two services are comparable in intensity and work. However, the RUC did note that the surveyed code contains two additional minutes of pre-service time, which is related to the physician management of the injection. **With a direct crosswalk from reference code 70496, the RUC recommends a work RVU of 1.75 for CPT code 784X2.**

784X1

The RUC reviewed the specialty society's survey results and work RVUs recommended by the specialty society for 784X1. The RUC discussed the survey results and noted that there was an exceptionally high median survey performance rate among the 83 respondents, which adds significant support to the survey responses. The RUC agreed that that survey physician times of 10 minutes pre-service, 15 minutes intra-service, and 10 minutes immediate post-service time accurately reflect the time required to perform this service. However, the RUC agreed that the median work RVU of 1.50 was too high and did not accurately reflect the work being performed in the surveyed code. In order to maintain relativity with 784X2, the RUC derived the recommended RVU for 784X1 by calculating the relationship between the median survey RVUs of X1 and X2 and maintaining this relationship between the recommended RVU for 784X1 and 784X2. The survey work RVU relationship between 784X1 : 784X2 is (1.50 : 1.87) resulting in a relationship between the recommended RVU for 784X1 : 784X2 (1.40 : 1.75).

784X1 =	1.50	*1.40*
784X2 =	1.87	1.75

The RUC agreed that this computed work RVU, 1.40 RVUs, maintains the relativity of the original survey data and is an appropriate measure of the work for 784X1. The RUC also compared 784X1 to 45308, *Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery* (work RVU = 1.40, intra-service time = 15 minutes) and agreed that it supports the RUC's recommendation of 1.40 work RVUs for 784X1. **The RUC recommends a work RVU of 1.40 for CPT code 784X1, which maintains the relativity between the 784X1 and 784X2 and is the appropriate value for the service.**

784X3

The RUC reviewed the survey results for 784X3 agreed with the specialty society that the survey median physician times were too high, and did not reflect the time required to perform this service. The RUC agreed that the surveyed 25th percentile physician time (pre-service = 5, intra-service = 10, post-service = 5) and 25th percentile work RVU of 1.00 accurately reflects the work and time required to perform this service. In addition, the RUC compared 784X3 to 78315, *Bone*

and/or joint imaging; 3 phase study (work RVU = 1.02, pre-service = 5, intra-service = 8, post-service = 5) and noted the similarity in the physician time and work. **Therefore, the RUC recommends the 25th percentile time and work RVU of 1.00 for CPT code 784X3.**

784X4
The RUC reviewed the survey results for 784X4 and agreed with the specialty society that the survey median physician times were too high, and did not accurately reflect the time required to perform this service. The RUC agreed that the surveyed 25th percentile times (pre-service = 5, intra-service = 15, post-service = 5) and that the 25th percentile work RVU of 1.34 accurately reflect the work and time required to perform this service. In addition, the RUC compared 784X3 to 73721, *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU = 1.35, pre-service = 0, intra-service = 20, post-service = 0). The RUC agreed that 73721 was a good alternative reference code because the physician work for both codes is similar and the total physician times are the same, though the intra-service work of 73721 is slightly more intense. Based on the survey results and similarity to the reference code, the RUC agrees that the 25th percentile work RVU is appropriate. **Therefore, the RUC recommends the 25th percentile time and work RVU of 1.34 for CPT code 784X4.**

PLI
The RUC recommends that the PLI RVUS be cross-walked from the original base-codes: 784X1 = 78464, 784X2 = 78465, 784X3 = 78460, and 784X3 = 78461. The RUC also recommends that the PLI RVU for the technical component of each service be 0.00, and the PLI RVU be applied only to the physician component.

Practice Expense
The RUC reviewed the practice expense inputs approved by the PE Subcommittee and accepted them.

Peripheral Electrical Bioimpedance (Tab 17)

In October 2008 the CPT Editorial Panel revised code 93701 *Bioimpedance derived physiologic cardiovascular analysis* to fully describe all types of bioimpedance procedures presently in use. In 2001, the RUC recommended 0.00 physician work RVUs for 93701, as the physician work of reviewing this computer generated report is included as part of an associated E/M service. The RUC agreed the change was editorial. **The RUC reaffirmed their previous recommendation and recommends 0.00 work RVUs for 93701.**

Nerve Conduction Tests (Tab 18)

Reviewed by Facilitation Committee #2
Gregory Barkley, MD, American Academy of Neurology (AAN); Andrea Boon, MD, American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM); Neil Busis, MD, AAN; Lee Mills, MD American Academy of Family Physicians; John A. Seibel, MD, MACE, American Association of Clinical Endocrinologists; Benn Smith, MD, AANEM

The CPT Editorial Panel created one new Category I CPT code to describe a new nerve conduction test performed with newer technologies that differ from traditional technologies. The Editorial Panel created, 9590X1, *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study; each limb, includes F-wave study when performed,*

with interpretation and report at its October 2008 Meeting. The Editorial Panel specified that this codes may be reported only once per limb studied.

The specialty societies presented survey data from 75 physicians; however, the median service performance rate of all surveyees was zero. Following RUC policy, the specialties provided additional data from their original survey, including the compilation of responses from physicians with a service performance rate of at least one and the compilation of responses from physicians with a service performance rate of zero, which the RUC compared with the aggregate data in the Summary of Recommendation form. The specialties also provided a complete description of the work that is included in the procedure to support the contention that there is physician work involved since it was noted that 21 of the survey respondents compared the new code to a reference code with no physician work. Based on this description and the overall survey results, the RUC agreed that although the median survey work RVUs and some of the surveyed physician times are inflated, physician work is appropriate. The RUC reviewed the times recommended by the specialties and noted that there is no pre-service or post-service physician time and that the physician work is only performed during the intra-service period. Specifically, the RUC decided that the physician work described by the specialties within the pre-service time is included within the evaluation and management service that is typically reported on the same day and that the physician work described by the specialties within the post-service time is inappropriate and is included within the five minutes of intra-service time. The RUC compared 9590X1 to 76977, *Ultrasound bone density measurement and interpretation, peripheral site(s), any method* (work RVU = 0.05, intra-service = 5 minutes), which is identical in physician time and work. The RUC agreed that 76977 serves as a direct comparison code and the appropriate work RVU for 9590X1 is 0.05, based on this magnitude estimation. The Committee also noted that 0.05 is the survey 25th percentile work RVU. The RUC also commented that this service is Modifier 51 exempt and assumed it may often be reported more than once, supporting pre- and post-service times of 0 minutes. **Therefore, the RUC recommends a work RVU of 0.05, no pre- or post-service time and five minutes of intra-service time for 9590X1.**

Practice Expense
The RUC reviewed the practice expense inputs and revised the clinical staff time to reflect that multiple units of services are typically reported.

PLI
The RUC recommends a PLI crosswalk to the key reference service, 76977-26 (the professional component only).

New Technology
The RUC recommends that 9590X1 is placed on the New Technology list.

X. CMS Requests

<u>Foot Bone Resection Partial (Tab 19)</u>
Reviewed by Facilitation Committee #1
William Creevy, MD, American Academy Orthopaedic Surgeons, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Frank Spinosa, DPM Robb Mothershed, DPM and Timothy Tillo, DPM, American Podiatric Medical Association

CPT codes 28120, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus* and 28122, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis*

or bossing); tarsal or metatarsal bone, except talus or calcaneus were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicated that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

28120

The RUC first considered the compelling evidence presented by the specialty societies to review the work of 28120. The specialty societies indicated that during the Harvard studies, the wrong specialty was surveyed. The original surveys included on orthopaedic surgeons; however, podiatrists are the primary providers. Further, there is a rank order anomaly between 28120 and 28122. Currently, 28122 requires less physician time, but has a higher work RVU. **The RUC agreed that compelling evidence exists to review the work RVU of 28120.**

The specialty society presented the results of a survey of 52 orthopaedic surgeons and podiatrists. 65% of the survey respondents indicated that patients spend at least one night in the hospital and are seen post-operatively by the physician on the same day of surgery following the procedure. The RUC agreed that the inclusion of one 99231 hospital visit was appropriate. The RUC also agreed with the two 99213 and three 99212 post-operative office visits as indicated by the surveyees. The RUC understands that the first two visits include a splint/bandage change. The physician continues to see the patient once per week until the wound heals and physical therapy begins. The RUC reviewed the physician time and noted that the pre-service positioning time should be reduced to 10 minutes to more accurately reflect the service. Lastly, the RUC discussed the proposed work RVU and agreed with the survey 25th percentile work RVU of 8.08. The RUC compared this service to several other codes to support the work RVU including, 15100, *Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)* (work RVU = 9.74, pre-service = 65, intra-service = 60, post-service = 20) and 29891, *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU = 9.47, pre-service = 50, intra-service = 60, post-service = 25). The RUC compared 28120 to 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88) and noted that the codes are similar, but that 28120 requires greater intensity and complexity. The RUC also agreed that the work RVU of 8.08 corrects an existing rank order anomaly with 28122, which has a work RVU of 7.56. **Therefore, the RUC recommends the survey 25th percentile work RVU of 8.08 for CPT code 28120.**

28122

The RUC first considered the compelling evidence presented by the specialty societies to review the work of 28122. The specialty societies indicated that during the Harvard studies, the wrong specialty was surveyed. The original surveys included on orthopaedic surgeons; however, podiatrists are the primary providers. Further, there is a rank order anomaly between 28120 and 28122. Currently, 28120 requires greater physician time, but has a lower work RVU. **The RUC agreed that compelling evidence exists to review the work RVU of 28122.**

The specialty society presented the results of a survey of 52 orthopaedic surgeons and podiatrists. 67% of the survey respondents indicated that patients spend at least one night in the hospital and are seen post-operatively by the physician on the same day of surgery following the procedure. The RUC agreed that the inclusion of one 99231 hospital visit is appropriate. The RUC also agreed with the two 99213 and two 99212 post-operative office visits as indicated by the surveyees. The RUC reviewed the physician time and noted that the pre-service positioning time should be reduced to 10 minutes to more accurately reflect the service. Lastly, the RUC discussed the proposed work RVU and agreed that there is no compelling evidence to change the work RVU from its current value, which is 7.56. The RUC compared this service to several other codes to support the work RVU including, 33207, *Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU = 8.00, pre-service = 47.5, intra-service = 60, post-service = 30) and 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88, pre-service = 50, intra-service = 70, post-service = 20). The RUC also agreed that maintaining the current work RVU of 7.56 is appropriate in relation to its recommendation for 28120. **Therefore, the RUC recommends the maintaining the current work RVU of 7.56 for 28120.**

Practice Expense
The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

Foot Arthrodesis (Tab 20)
Reviewed by Facilitation Committee #1
William Creevy, MD, American Academy Orthopaedic Surgeons, Tye Ouzounian, MD, American Orthopaedic Foot and Ankle Society, Frank Spinosa, DPM Robb Mothershed, DPM and Timothy Tillo, DPM, American Podiatric Medical Association

CPT codes 28725, *Arthrodesis; subtalar* and 28122, *Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

28725
The RUC reviewed the specialty's evidence in order to recommend increases in the current work RVU for 28725. The specialty noted that the procedure has never been reviewed by the RUC and that podiatrists, who perform 31% of the procedures were not included in the original Harvard survey. The RUC did not agree that compelling evidence existed to justify an increase in work RVU, but did agree that there was evidence to support a recommendation by the specialty to maintain the current work RVU. The specialty society presented the results of a survey of 71 orthopaedic surgeons and podiatrists. The survey data showed that 74% of patients stay overnight following the surgery. The specialty also indicated that the typical patient is seen on

the same day following the procedure as well as the next day. Because these patients typically have several morbidities, including diabetes, they require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. Therefore, the RUC agreed that one 99231 hospital visit as well as a full 99238 discharge day management service are appropriate. The RUC reviewed the survey data and agreed with the survey median physician times of 70 pre-service, 90 intra-service, and 20 immediate post-service. The RUC was convinced, following a review of the survey data, that that the survey physician time and visit data accurately the work included in the procedure. Based on its review of the survey data, the RUC agreed that the current work RVU of 11.97 was the appropriate valuation of the work involved in the service. The RUC noted that the current work RVU is below the survey 25th percentile work RVU. The RUC also reviewed several reference codes to support a work RVU of 11.97 for 28725. Codes 28261, *Capsulotomy, midfoot; with tendon lengthening*, (work RVU = 12.91, pre-service = 60, intra-service = 103, post-service = 30) and 25608, *Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments*, (10.86, pre-service = 65, intra-service = 90, post-service = 30). **The RUC recommends maintaining the current work RVU of 11.97 and accepting the median survey physician time and post-operative visits for CPT code 28725.**

28730

The RUC reviewed the specialty's evidence in order to recommend increases in the current work RVU for 28730. The specialty noted that the procedure has never been reviewed by the RUC and that podiatrists, who perform 33% of the procedures were not included in the original Harvard survey. The RUC did not agree that compelling evidence existed to justify an increase in work RVU, but did agree that there was evidence to support a recommendation by the specialty to maintain the current work RVU. The specialty society presented the results of a survey of 71 orthopaedic surgeons and podiatrists. The survey data showed that 74% of patients stay overnight following the surgery. The specialty also indicated that the typical patient is seen on the same day following the procedure as well as the next day. Because these patients typically have several morbidities, including diabetes, they require close observation of their medical status as well as wound inspection and monitoring of lower extremity neurovascular status. Therefore, the RUC agreed that one 99231 hospital visit as well as a full 99238 discharge day management service are appropriate. The RUC survey data and agreed with the survey median physician times of 70 pre-service, 100 intra-service, and 20 immediate post-service. The RUC was convinced, following a review of the survey data, that the survey physician time and visit data accurately the work included in the procedure. Based on its review of the survey data, the RUC agreed that the current work RVU of 12.21 was the appropriate valuation of the work involved in the service. The RUC also noted that the current work RVU is below the survey 25th percentile work RVU. The RUC also reviewed several reference codes to support a work RVU of 12.21 for 28730. 28309, *Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)* (work RVU = 13.96, pre-service = 60, intra-service = 110, post-service = 30) and 29862, *Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum* (work RVU = 10.97, pre-service = 75, intra-service = 100, post-service = 30). The RUC noted that while the procedures are similar in intensity and complexity, 28730 required less intra-service time than 28309, which accounts for the smaller work RVU. The RUC also commented that 28730 is similar to 29862, which both require 100 minutes of intra-service time, but requires slightly more complexity, which supports the higher work RVU of 28730. **The RUC recommends maintaining the current work RVU of 12.21 and accepting the median survey physician time and post-operative visits for CPT code 28730.**

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

Interventional Radiology Procedures – PE Only (Tab 21)
American College of Radiology
Society of Interventional Radiology

In June 2008, CMS requested the RUC to make direct practice expense recommendations in the non-facility setting for the following CPT Codes:

36481 *Percutaneous portal vein catheterization by any method*
37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated*
47382 *Ablation, one or more liver tumor(s), percutaneous, radiofrequency*
50200 *Renal biopsy; percutaneous, by trocar or needle*

At the October 2008 RUC meeting all of the CMS requested interventional radiology procedures were reviewed for practice expense and recommendations were made to place all of the procedures on CPT's appendix G to indicate that Moderate Sedation is inherent to these procedures. At that time, the RUC tabled code 36481 after determining that the medical supplies and equipment time included in the recommendation overlapped other services, such as imaging services, that are typically billed at the same time. The RUC also determined the specialty society recommendation lacked RUC standards for practice expense and that other similar services recently reviewed by the RUC may require revised recommendations. Codes 75885 *Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation* and 75887 *Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation* were identified as services to be reviewed concurrently with 36481 at the February 2009 RUC meeting.

At the February 2009 RUC meeting the RUC reviewed the practice expense input recommendations for codes 36481, 75885, and 75887 in tandem as to prevent any overlap or double counting of clinical staff, medical supplies, and/or equipment. The RUC made a minor change to a medical supply and agreed with the remainder of the specialty society's recommendations. **The RUC recommends the attached non-facility direct practice expense inputs for CPT codes 36481, 75885, and 75887.**

Arteriovenous Procedure (Tab 22)
Gary Seabrook MD FACS, Matthew Sideman MD FACS, David Han MD FACS, Robert Zwolak MD FACS, and Michael Sutherland MD FACS, Society for Vascular Surgery and Christopher Senkowski, MD, FACS American College of Surgeons

CPT code 36825, *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft*, was identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, The RUC removed the hospital visits from the service with no impact on the

associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

The RUC first reviewed 36825 to determine if there was compelling evidence to justify a review of the work RVU for a potential increase in value. The specialty society indicated that the service had never been reviewed by the RUC and was originally valued during the Harvard studies. Additionally, the specialty commented that the work involved in the procedure has changed due to a change in the typical patient since its inception. The procedure, which is used to create access for hemodialysis patients, is used less frequently now and on much more complicated patients, than it was in the past. Because of the "fistula first" initiative, patients are typically not undergoing this procedure unless they have failed a direct anastomosis. Since this is a secondary procedure, the patients that undergo a 36825 are typically older, sicker, and have no available hemodialysis access in their arms. Therefore, the physician work has changed. **The RUC agreed that compelling evidence to review this procedure exists.**

The specialty society presented the data from a survey of 31 general and vascular surgeons. The RUC first reviewed the physician time and post-operative evaluation and management visits. According to the survey, 74% of patients are kept overnight and more than 80% of those patients are seen on the evening of the day of the procedure and again the following day before being discharged. Because of this survey data, the RUC agreed that 36825 includes a full 99238 discharge day management visit as well as one 99231 hospital visit. The RUC also agreed with the survey post-service office visits, which include one 99212 and two 99213 visits. The RUC also agreed with the survey median intra-service time of 120 minutes, the survey median immediate post-service time of 30 minutes, and pre-service time package #4, difficult patient/difficult procedure, with an additional seven minutes of positioning time. Lastly, the RUC reviewed the recommended work RVU and disagreed with the specialty society expert panel recommendation. The RUC considered the survey data in comparison to the MPC reference code selected by the specialty, 36819, *Arteriovenous anastomosis, open; by upper arm basilic vein transposition,* (work RVU = 14.39). The RUC agreed that the survey median work RVU of 18.00 was too high, but that the survey 25th percentile work RVU was appropriate. The RUC reviewed 36819 and noted that the reference service and the surveyed code contain identical intra-service times of 120 minutes. The specialty noted that there are two differences between 36825 and 36819 that warrant a higher RVU for 36825: (1) 36825 requires a vein that is harvested from a remote location. As a result, it requires two anastomoses, one where the vein is sewn to the inflow artery and a second where it is attached to the outflow vein. (2) The surveyed code includes an additional 99213 office visit. As a result, the RUC agreed that the survey 25th percentile work RVU of 15.00 is appropriate in comparison to 36819 for 36825. **The RUC recommends the specialty's survey 25th percentile work RVU of 15.00 for CPT code 36825.**

Practice Expense
The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

Parotid Tumor Excision (Tab 23)

Jane Dillon, MD, American Academy of Otolaryngology – Head and Neck Surgery and Christopher Senkowski, MD, FACS American College of Surgeons

CPT codes 42415, *Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve and 42420, Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

42415

The specialty society agreed that there was not compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 42415. However, the specialty presented data from a survey of 76 otolaryngologists and general surgeons as well as consensus recommendations from an expert panel of otolaryngologists and general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 97% of respondents perform the procedure in the hospital. Of those 97% respondents, 91% stated that the patient stays overnight. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. The specialty societies indicated that an additional 9 minutes of positioning time is necessary to assist the patient with the shoulder roll, rotating and stabilizing the head. Further, the survey and panel, based on the survey median, recommended an intra-service time of 150 minutes and immediate post-service time of 20 minutes. Lastly, the specialty presented data that one 99238 discharge day management service, and one 99212 and two 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC also compared 42415 to the key reference service, 60271, *Thyroidectomy, including substernal thyroid; cervical approach*, (work RVU = 17.54, intra-time = 150), which supports the current work RVU of 17.99. The RUC also noted that the survey 25th percentile work RVU was 18.00. **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 17.99 for CPT code 42415.**

42420

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 42420. However, the specialty presented data from a survey of 76 otolaryngologists and general surgeons as well as consensus recommendations from an expert panel of otolaryngologists and general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 100% of respondents perform the procedure in the hospital. Of those respondents, 98% stated that the patient stays overnight, and 62% stated that the patient

stays longer than one day. The consensus panel indicated that the typical length of stay for this procedure is 3 days monitoring for airway patency, hematoma formation, facial nerve function, and control of pain and nausea is necessary. The specialty society survey and panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. The specialty societies indicated that an additional 9 minutes of positioning time is necessary to assist the patient with the shoulder roll, rotating and stabilizing the head. Further, the survey and panel, based on the survey median, recommended an intra-service time of 180 minutes and immediate post-service time of 20 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99232 hospital visit, one 99238 discharge day management service, and one 99212 and two 99213 office visits are included. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared the 42420 to MPC code 35141, *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, common femoral artery (profunda femoris, superficial femoral),* (work RVU = 20.83, intra-time = 150 minutes) and code 34471, *Thrombectomy, direct or with catheter; subclavian vein, by neck incision* (work RVU = 21.00 intra-service = 180) and agreed that the two services support the current work RVU of 20.87. The RUC also noted that the survey respondents indicated a median work RVU of 25.00 work RVUs and a 25th percentile of 23.36, comparing the work of 42420 to 38724, *Cervical lymphadenectomy (modified radical neck dissection)* (work RVU = 23.72). **The RUC recommends the new physician times as well as hospital and office visits, but recommends maintaining the current work RVU of 20.87 for CPT code 42420.**

Practice Expense
The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits and that the physician-assist time be modified to reflect changes to the intra-service time.

Hernia Repair (Tab 24)
Christopher Senkowski, MD, FACS and Charles Mabry, MD, FACS, American College of Surgeons

CPT codes 49507, *Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated,* 49521, *Repair recurrent inguinal hernia, any age; incarcerated or strangulated,* and 49587, *Repair umbilical hernia, age 5 years or older; incarcerated or strangulated* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008 and these procedures were surveyed for review at the February 2009 RUC Meeting.

49507
The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49507.

To support the current work RVU, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 98% of respondents perform the procedure in the hospital. Of those 98%, 83% stay overnight, and of those 83%, 73% (or 59% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 70 minutes and immediate post-service time of 30 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212 and one 99213 office visits are typical. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49507 to the key reference service 49505, *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU = 7.88 intra-time = 70 minutes). The RUC also compared 49507 to 54512, Excision of extraparenchymal lesion of testis (work RVU = 9.22, pre-time = 50 minutes, intra-time = 70 minutes, post-service = 30) and noted that there is more pre-service time in the surveyed code (63 versus 50 minutes) accounting for the slight difference in work RVU. The RUC noted that the reference service contains less pre-service and immediate post-service and is less intense than the surveyed code. The RUC also noted that the 25th percentile survey work RVU was 9.91 and the median work RVU was 11.00. **The RUC recommends the new survey times as well as hospital and office visits, but recommends maintaining the current work RVU of 9.97 for CPT code 49507.**

49521

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49521. To support the current work RVU, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 99% of respondents perform the procedure in the hospital. Of those 99%, 82% stay overnight, and of those 82%, 68% (or 55% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 90 minutes and immediate post-service time of 30 minutes. During the immediate post-service work, the physician protects the wound with a hand while the patient comes out of anesthesia so that an unrestrained cough does not disrupt the repair. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212 and one 99213 office visits are typical. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49521 to the key reference service, 49520, *Repair recurrent inguinal hernia, any age;*

reducible, (work RVU = 9.91, intra-service time = 60 minutes). The RUC noted that the reference service requires 30 minutes less intra-service time and involves less intensity and complexity that the survey code. The RUC also compared 49521 to 49652, *Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible* (work RVU = 12.80, pre-time = 75, intra-time = 90, immediate post-time = 30) and noted that the two codes are similar and have identical intra- and immediate post-service time, but that the reference code has slightly more pre-service time accounting for the difference in work RVU. The RUC also noted that the survey respondents indicated a median work RVU of 14.00 and a 25th percentile work RVU of 11.00. **The RUC recommends the new survey times as well as hospital and office visits, but recommends maintaining the current work RVU of 12.36 for CPT code 49521.**

49587

The specialty society agreed that there was no compelling evidence to support a review of the physician work in order to recommend a higher work RVU than is currently assigned to 49587. To support the current work RVU, the specialty presented data from a survey of 84 general surgeons and consensus recommendations from an expert panel of general surgeons to validate physician time and post-operative visits. The survey results and expert panel consensus show that patients are typically kept overnight in the hospital following this procedure. The survey results indicated that 100% of respondents perform the procedure in the hospital. Of those, 71% stay overnight, and of those 71%, 77% (or 55% of all patients) are seen for an evaluation and management visit on the same day. The surveyees and the specialty expert panel noted and the RUC agreed that typically patients require close monitoring the day of and the day after the procedure for problems such as ileus, intestinal ischemia, and urinary retention. There is also a significant amount of pain management. A patient will not be discharged until there is a return of bowel function, the patient is taking adequate nutrition, and there is adequate pain control with oral analgesics. The specialty society panel indicated pre-service time package four applied – facility, difficult patient, difficult procedure. Further, the survey and panel recommended an intra-service time of 60 minutes and immediate post-service time of 30 minutes. Lastly, the specialty presented data that one 99231 hospital visit, one 99238 discharge day management service, and one 99212 and one 99213 office visits are typical. The RUC agreed with the specialty society survey results regarding physician time and post-operative visits. The RUC compared 49587 to the key reference service, 49585, *Repair umbilical hernia, age 5 years or older; reducible*, (work RVU = 6.51, intra-service time = 45 minutes). The RUC noted that the reference service requires 15 fewer minutes and requires less intensity and complexity than the surveyed code. The RUC also compared 49587 to 49572, *Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated* (work RVU = 7.79, pre-time = 45 intra-time = 60, immediate post-time = 30). The RUC agreed that the two codes are similar, but that the difference in intra-service accounts for the slight difference in work RVUs. The RUC also noted that the survey respondents indicated a median work RVU of 11.50 work RVUs. **The RUC recommends the new survey times as well as hospital and office visits, but recommends maintaining the current work RVU of 7.96 for CPT code 49587.**

Practice Expense

The RUC recommends that the non-facility practice expense inputs be modified to reflect changes to the post-operative office visits.

<u>Cryoablation of Prostate (Tab 25)</u>

James Giblin, MD, Richard Gilbert, MD, and Mark Chelsky, MD, American Urological Association

In June 2008, CMS requested the RUC to review non-facility setting direct practice expense recommendations for CPT Code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement).* The American Urological Association's Quality Improvement and Patient Safety Committee maintained that 55873 may be performed in the office setting assuming that a Class C surgical facility designation for anesthesia has been achieved. The RUC reviewed the direct practice expense recommendation in the non-facility setting as presented by the specialty and realized the service was initially reviewed as a new code by the RUC in February 2001. RUC members believed that the intra-service physician time since the RUC' initial review had declined (from 200 minutes) as the service is now more often performed. The RUC agreed with the specialty that the service should be surveyed for physician work for presentation with revised direct practice expense input information at the RUC's January 29 – February 1, 2009 meeting.

At the RUC's January 29 – February 1, 2009 meeting the specialty society provided a clear description of the service being provided. The survey respondents had chosen CPT code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* (Work RVU = 13.31) as its key reference service. RUC members had expressed their concern regarding the high intra-service work per unit of time (IWPUT) and the change in intra-service time from the previous survey performed eight years prior. The specialty explained that the performance of the procedure has changed and the intensity had increased. The monitoring of multiple body data points for temperature change simultaneously, the placement of multiple probes, and the reduction of time of obtaining and maintaining a -40F ice ball formation, has increased the intensity and reduced the intra-service time. In addition, it was explained that the risk of patient injury during the entire procedure is quite high.

The RUC agreed that the work value for code 55873 is similar to the specialty's key reference service 55875. However, the RUC did not agree with the specialty's recommended value of 15.50. The RUC reviewed its previous recommendation from February 2001 which was established through a building block methodology with an intra-service work per unit of time (IWPUT) of 0.071. RUC members understood that from the recent survey the intra-service time is lower (100 rather than 200 minutes) and a higher intensity and complexity has been recognized than when the code was first surveyed. Due to a more complex and intense monitoring of the organs and ablated area, RUC members concurred that the intensity of 55873 is between the specialty survey's key reference service code 55873 (IWPUT = 0.0948) and its originally determined intensity of 0.071 established from CPT code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (Work RVU = 30.52). The RUC agreed the IWPUT to be approximately 0.083 which is precisely between the IWPUT of 55845 and 55873. Using the specialty's surveyed physician time components and an IWPUT of 0.083 the RUC constructed a building block methodology that resulted in a work relative value of **13.45** for CPT code 55873.

The RUC agreed that an anchor code and a building block approach would also be useful at establishing the correct value. The RUC considered several similar services with a range of complexities including code 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (Work RVU = 9.08, IWPUT = 0.064). Code 50593 has 90 minutes of intra-service time, however the ultrasound guidance needed to place the needles is coded separately, and the insertion of a superpubic catheter is required for cryoablation of the prostate. Adding up these components was agreed be appropriate in establishing the physician work value for code 55873.

The RUC agreed that although the physician work for code 55873 is similar to code 50593, it is more intense and concurred the intensity of 0.083 needed to be maintained.

The RUC then took 90 minutes of intra-service work time out of code 50593 at an IWPUT of 0.064 (0.064 X 90 = 5.76) and replaced with 90 minutes of work at an IWPUT of 0.083 (0.083 X 90 = 7.47) to arrive at a beginning value of 10.79. (7.47 – 5.76 = 1.71 RVUs + 9.08 = 10.79). The insertion of a superpubic catheter and the ultrasound guidance are then added to arrive at a value similar to 13.45 as shown below.

This building block utilizes the work the following three codes:
50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (Work RVU = 9.08 +1.71 (intensity RVU difference) = 10.79.
51102 *Aspiration of bladder; with insertion of suprapubic catheter* (Work RVU = 2.70 X 50% (multiple procedure reduction) = 1.35)
76965 *Ultrasonic guidance for interstitial radioelement application* (Work RVU = 1.34)

10.79
+1.35
+1.34
13.48

The RUC's building block and IWPUT methodologies led them approximately to the same physician work value of 13.45 RVUs. The RUC also reviewed and compared the work of codes 49565 *Repair recurrent incisional or ventral hernia; reducible* (Work RVU = 12.29, 100 minutes intra-service time), 58550 *Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;* (Work RVU = 14.97, 100 minutes intra-service time), and 29806 *Arthroscopy, shoulder, surgical; capsulorrhaphy* (Work RVU = 14.95, 100 minutes intra-service time). After developing a building block methodology, reviewing similar procedures with 100 minutes of intra-service time and intensity ranges, **the RUC recommends a relative work value of 13.45 for CPT code 55873.** This value preserves the rank order between 55873 and its key reference code 55875.

Practice Expense: The RUC reviewed the direct practice expense inputs as recommended by the specialty and made some minor edits to the clinical labor and medical supplies to reflect the typical patient service.

Hysterectomy – PE Only (Tab 26)
American College of Obstetricians and Gynecologists

At the request from the Centers for Medicare and Medicaid Services, the RUC reviewed a list of direct practice expense input changes specific to the following CPT codes:
58555 *Hysteroscopy, diagnostic (separate procedure)*
58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C*
58562 *Hysteroscopy, surgical; with removal of impacted foreign body*
58563 *Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)*

The specialty society noticed that some practice expense items for the typical service, needed to be included. The RUC reviewed these practice expense additions carefully and agreed with the specialty's recommendations. They agreed that a pack for cleaning surgical instruments, already included in the practice expense items for these services, is necessary in addition to the pack for cleaning and disinfecting the endoscope because the hysteroscopy services need a speculum, a tenaculum, and other sterile equipment to access the uterus, in addition to the endoscopy instruments. The cystoscopy pack is required for installation of the distention fluid and is in addition to the exam pack that is now recommended. **The RUC recommends the following additions and deletions to the direct practice expense inputs:**

1. **58555**- *Hysteroscopy, diagnostic (separate procedure)*
    a. SA058- Pack, Urology cystology visit
    b. SA042-Pack, Cleaning and disinfecting, endoscope
    c. SB001-Cap, Surgical
    d. SB027-Gown, Staff, impervious
    e. SB034-Mask Surgical, with face shield
    f. SB039-Shoe Cover, Surgical
    g. SJ036- Monsel's Soln
    h. SC053- Syringe, 20 ml
    i. **Remove Items:** (SB024-Gloves- sterile, SJ041-Povidone Soln Betadine, SC062 Toomey syringe)

2. **58558**- *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C*
    a. SA058- Pack, Urology cystology visit
    b. SA042-Pack, Cleaning and disinfecting, endoscope
    c. SB001-Cap, Surgical
    d. SB027-Gown, Staff, impervious
    e. SB034-Mask Surgical, with face shield
    f. SB039-Shoe Cover, Surgical
    g. SJ036- Monsel's Soln
    h. SC053- Syringe, 20 ml
    i. **Remove Items:** (SB024 Gloves-sterile, SJ041-Providone Soln Betadine, SC062 Toomey syringe)

3. **58562**- *Hysteroscopy, surgical; with removal of impacted foreign bo*dy
    a. SA058- Pack, Urology cystology visit
    b. SA042-Pack, Cleaning and disinfecting, endoscope
    c. SB001-Cap, Surgical

d. SB027-Gown, Staff, impervious
e. SB034-Mask Surgical, with face shield
f. SB039-Shoe Cover, Surgical
g. SJ036- Monsel's Soln
h. SC053- Syringe, 20 ml
i. **Remove Items:** (SB024 Gloves-sterile, SJ041-Providone Soln Betadine, SC062 Toomey syringe)

4. **58563**- *Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)*
    a. SA058- Pack, Urology cystology visit
    b. SA042-Pack, Cleaning and disinfecting, endoscope
    c. **Remove Items:** (SM018 Glutaraldehyde 3.4% Cidex, Maxicide, Wavicide, SH048-Lidocaine 2% jelly, topical (Xylocaine), SH069- Sodium chloride 0.9% irrigation (500-1000ml), SD129 Tubing, irrigation(Cysto), SD118 (-1) vaginal specula)

Obstetric Procedures (Tab 27)
American Academy of Family Physicians, American College of Obstetricians and Gynecologists

The Five Year Review Identification Workgroup identified the following codes as potentially misvalued through the High IWPUT Screen and the RUC recommended that they be surveyed: 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59515, 59610, 59612, 59614, 59618, 59620, and 59622**.** The RUC referred development of an MMM survey instrument to the Research Subcommittee with input from the specialty society at its October 2008 meeting. The Research Subcommittee has worked with the specialty since that time to develop a survey method to review these codes. The survey and process will be finalized by the April 2009 RUC meeting so data can be collected and presented at the October 2009 RUC meeting.

Cranial Neurostimulators (Tab 28)
American Association of Neurological Surgeons/Congress of Neurological Surgeons

CPT codes 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array*, and 64753 *Incision for implantation of neurostimulator electrodes; cranial nerve* were identified by the Five-Year Review Identification Workgroup as potentially misvalued through its Site of Service Anomaly screen in September 2007. The Workgroup reviewed all services that include inpatient hospital visits within their global periods, but are performed less than 50% of the time in the inpatient setting, according to recent Medicare utilization data. The RUC originally recommended a two-step action. First, the RUC removed the hospital visits from the service with no impact on the associated work RVU, which CMS agreed with. Second, the RUC recommended that services be surveyed. At the April 2008 RUC Meeting, the specialty societies presented data that indicate that although these procedures are reported as outpatient procedures more than 50% of the time, patients typically spend at least one night in the hospital. The RUC deferred action on these issues until an adequate survey instrument was developed. The RUC approved a revised survey instrument in October 2008.

The specialty societies presented information to the RUC that as a result of recent developments in the use of vagal nerve stimulators, there are some concerns about the use of 61885 and 64753 with respect to these procedures. The specialty societies are bringing forth a CPT coding proposal to revise 61885 and 64573 to better describe revision of a vagal nerve stimulator lead and the placement of the pulse generator and replacement or revision of the vagus nerve electrode. The specialties requested that the RUC review of CPT codes 61885 and 64753 be postponed until a revision of the descriptors for these codes has been reviewed by the CPT Editorial Panel.

The RUC agreed with the specialty societies and recommended referral of 61885 and 64573 to the CPT Editorial Panel.

End-Stage Renal Disease – PE and Physician Time Only (Tab 29)
Renal Physicians Association

In February 2008, the RUC reviewed physician work and practice expense recommendations for the adult and pediatric end stage renal dialysis services. These recommendations were submitted to CMS in May 2008 for implementation beginning January 2009. However, in the 2009 Final Rule, CMS requested the RUC to again review its practice expense recommendations to make certain that they accurately reflect the typical direct resources required for these services. In addition, CMS requested the RUC to review the physician time for CPT codes 90960 and 90961.

As of the date of the February 2009 RUC agenda book publication AMA RUC staff had not received comments from the Renal Physicians Association (RPA). RUC members discussed the issue and agreed that RPA staff and advisors were unprepared to provide a cohesive recommendation to the RUC at that time and asked that the issue be deferred to the April 2009 RUC meeting. **The RUC recommends that this issue be deferred to its next meeting in April 2009.**

Speech-Language Pathology – (Tab 30)
Jane Dillon, MD, American Academy of Otolaryngology – Head and Neck Surgery, Robert Fifer, PhD and Dee Adams Nikjeh, PhD, American Speech-Language and Hearing Association

On July 15 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech language pathologists may independently report services they provide to Medicare patients. Starting in July 2009, speech language pathologists will be able to bill Medicare independently as private practitioners.

On October 9, 2008, the American Speech-Language-Hearing Association (ASHA) sent a request to CMS that in light of the recent legislation, that speech language pathologists services be based on professional work values and not through the practice expense component. CMS requested that the RUC review the speech language codes for professional work as requested by ASHA. ASHA indicated that it will survey the 13 speech language pathology codes over the course of the CPT 2010 and CPT 2011 cycles.

At the February 2009 meeting, the RUC reviewed codes 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech* and 92610 *Evaluation of oral and pharyngeal swallowing function.*

92597
The RUC reviewed the survey data from 31 speech pathologists and 5 otolaryngologists for code 92597. The survey data between both specialties was comparable. The specialty societies confirmed that this service is not included in the 090-day global period of performing a laryngectomy 31360 *Laryngectomy; total, without radical neck dissection* or 31365 *Laryngectomy; total, with radical neck dissection* which does not involve placing a fistula or dilating a stoma. However, the specialty societies recommended and the RUC agreed that the survey respondents slightly overestimated the time required to perform this service. Therefore, the RUC recommends pre-service package 5-Non-facility procedure without sedation/anesthesia care (7 minutes evaluation), a reduction of the intra-service time by 15 minutes to 40 minutes, and the immediate post-service time by 2 minutes to 13 minutes. The RUC also compared 92597 to code 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-, 30 minutes intra- and 8 minutes immediate post-service time) and determined that 92597 required slightly more work and time to perform than 97001. The RUC determined that the decrease in physician time and survey median work RVU of 1.48 appropriately reflects the work required to perform this service. **The RUC recommends a work RVU of 1.48 for code 92597.**

92610
The RUC reviewed the survey data from 125 speech pathologists and 5 otolaryngologists for code 92610. The specialty society recommended and the RUC agreed that the survey respondents slightly overestimated the time required to perform this service. Therefore, the RUC recommends pre-service package 5-Procedure without sedation/anesthesia care (7 minutes evaluation), a reduction in the intra-service time by 10 minutes to 35 minutes, and a reduction the immediate post-service time by 5 minutes to 10 minutes. The RUC also compared 92610 to codes 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-, 30 minutes intra- and 8 minutes immediate post-service time) and 92557 *Comprehensive audiometry threshold evaluation and speech recognition* (work RVU = 0.60 and 3minute pre-time, 20 minutes intra-time and 5 minutes immediate post service time). The RUC determined that 92610 required slightly more work and time to perform than 97001 and required approximately double that of the time and work required for 92557. The RUC determined that the decrease in physician time and surveyed 25th percentile work RVU of 1.30 appropriately reflects the work required to perform this service. **The RUC recommends a work RVU of 1.30 for code 92610.**

Practice Expense
The RUC recommends removing the associated speech language pathologists' time from the direct practice expense inputs, as all physician and speech pathologist work is captured in the work RVU. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

PLI
The RUC recommends that code 92610 be crosswalked to 92557.

<u>Cardiology Services - PE Only (Tab 31)</u>
American College of Cardiology

In September 2007, the RUC had reviewed its recommendations for physician work and practice expense for then new code 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography*. Code 93306 is a

bundled code comprised of codes 93307 *Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete,* 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* and 93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography).* At that time, the RUC made its practice expense recommendations based on the sum of the codes' parts. The RUC made minor edits to the recommended clinical labor and medical supplies, and the equipment was recommended to remain the same. These recommendations were then forwarded to CMS in 2008 for implementation in 2009.
In the 2009 Final Rule, CMS stated that prior to accepting the RUC's recommendation for code 93306, they would like the RUC to review the practice expense inputs of 93307, 93320, and 93325 to ensure that they are consistent with the recommended direct inputs for 93306. In the interim, they would continue to use the established practice expense RVUs for these services.
In February 2009, the RUC reviewed the practice expense inputs for codes 93307, 93320, and 93325 in comparison with 93306. The RUC understood that the sum of the practice expense inputs of codes 93307, 93320, and 93325 should be greater than the inputs for code 93306 because of economies of scale. The RUC agreed with the specialty's recommendations for clinical labor, medical supplies, and equipment. **The RUC recommends the attached practice expense direct inputs for codes 93307, 93320, and 93325.**

The CMS had also asked the RUC review the practice expense inputs of cardiac catheterization procedures (93510 – 93556) at its February 2009 meeting. As follow-up to a letter sent by the American College of Cardiology (ACC) in the summer of 2008. The ACC addressed the recent changes in the practice expense methodology that caused a substantial reduction in payment for cardiac catheterization services performed in the physician office setting. The ACC agrees with the practice expense input recommendations submitted by the RUC and accepted by CMS in 2007. **The RUC recommends no changes in the practice expense inputs for CPT codes 93017, 93510, 93543, 93545, 93555 and 93556.** The ACC noted that the society is developing a code proposal to re-write cardiac catheterization codes as bundled procedures for initial discussion at the June 2009 CPT Meeting.

Measure Blood Oxygen Level – PE Only (Tab 32)
American College of Chest Physicians, American Thoracic Society

In October 2008 the RUC's Five Year Identification Workgroup reviewed 94762 *Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)* as part of the CMS Fastest Growing Procedures screen and noted that it consists of practice expense only, with independent testing facilities predominantly performing this procedure. The Workgroup recommended that this code and the other codes in the family (94760 *Noninvasive ear or pulse oximetry for oxygen saturation; single determination* and 94761 *Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)*) be referred to the RUC's Practice Expense Subcommittee for review of the direct practice expense inputs.

In January 2009 the RUC carefully reviewed the typical clinical labor, medial supplies, and equipment recommended by the specialty society for codes 94760, 94761, and 94762. The RUC made few edits and changes and agreed with the modified specialty recommendations. **The RUC recommends the attached direct practice expense inputs for codes 94760, 94761, and 94762.**

Moderate Sedation Practice Expense Inputs – PE Only (Tab 33)
American College of Radiology, American Society of Neuroradiology, North American Spine Society, Society of Interventional Radiology

In 2005, CPT began identifying services in which moderate sedation is inherent and listed them in a separate addendum. The CMS reviewed its direct practice expense inputs database in 2008 and found 12 CPT codes that had moderate sedation practice expense inputs but were not listed in CPT's moderate sedation addendum. All 12 codes had been reviewed for practice expense direct inputs by the RUC prior to CPT 2005. CMS removed the moderate sedation inputs of all 12 codes for its 2009 physician fee schedule calculations and asked specialty societies to bring any of the codes forward to the RUC to reestablish the inputs. In February 2009, specialty societies contended that moderate sedation was inherent to two of these codes. The RUC discussed and agreed that moderate sedation was inherent in codes 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic,* and 22521 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar*. **The RUC recommends that the moderate sedation practice expense inputs be added back to codes 22520 and 22521. In addition, the RUC recommends codes 22520 and 22521 be placed on CPT's Appendix G, summary of CPT codes that include moderate (conscious) sedation.**

XI. Practice Expense Subcommittee (Tab 34)

Doctor Moran reported that Sherry Smith provided a PowerPoint presentation update on the AMA/Specialty Society Physician Practice Information Survey. Ms. Smith informed the RUC that the survey has concluded and that staff was waiting for the results to analyze. It is anticipated that a report on the results will be presented at the April RUC meeting.

The Practice Expense Subcommittee reviewed an array of direct practice expense recommendations for new, revised, and existing CPT codes referred to the group by CMS. The RUC approved the recommendations and will forward to CMS.

The Practice Expense Subcommittee expressed concern regarding requests to review services non-facility practice expense inputs that require general anesthesia.

The RUC approved the Practice Expense Subcommittee report and it is attached to these minutes.

XII. Research Subcommittee and Ad Hoc Pre-Time Workgroup (Tab 35)

Doctor Daniel Siegel delivered the Research Subcommittee Report to the RUC detailing the two items reviewed: 1.) A request from the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Family Physicians (AAFP) to review a MMM global survey instrument and 2.) A referral from the Ad Hoc Pre-Service Time Workgroup to review their recommendations pertaining to a request made by North American Spine Society (NASS) to review a cover letter and survey instrument for developing pre-service time standards.

The Research Subcommittee reviewed the MMM global survey instrument. **The RUC agreed with the Research Subcommittee recommended modifications to the cover letter and survey instrument including:**

- **Cover Letter –**
  - **In the first paragraph, the term "payment" should be replaced with the term "valuation" and**
  - **The sentence, "These 2 areas will be the most critical to evaluate, since they most likely require the most work and a significant amount of risk." should be deleted.**
- **Survey Instrument –**
  - **Question 2 – the first sentence should read, "This question refers only to services provided by the physician prior to the hospital admission for the onset of labor." Further, weeks 43 and 44 should be removed from the grid**
  - **Background for Question 3 – the second sentence should read, "It will also include any time spent with the patient and her family during her labor, interpretation of the fetal monitor strip and placement of monitors if indicated." Further, the third sentence should be bolded and read, "This is not limited to face to face time with the patient, but may also include time on the floor or unit providing non-face to face patient care, not including office time" In addition, the second paragraph should be deleted.**
  - **Question 3 – the question should read, "Please identify how much time is spent providing care to the patient during each encounter of management of typical labor. Further, the critical care time column should be removed and the non-critical care column should read, Minutes.**
  - **Question 4 – the question should read, "Which of the reference services on the attached list is most similar to the delivery portion of the maternity service described on the cover of this questionnaire, with respect to the intra-service work.**
  - **Question 6b – the third sentence, "For critical care service exceeding 74 minutes, use 99291 and the appropriate number of 99292 services." should be deleted. Further, the hospital visits (critical care) section should be deleted and prolonged services (99356 and 99357) should be added**
  - **Question 7 – the immediate post-service section should be deleted**

The Research Subcommittee reviewed the reference service list proposed by the societies and **With the addition of five services primarily performed by family physicians and the modifications listed in the report, the Research Subcommittee recommends and the RUC approves the proposed reference service list.**

The Research Subcommittee reviewed the cover letter and survey instrument proposed by NASS to develop pre-service time standards for spine surgery. **With a modification to the survey instrument as listed in the report, the Research Subcommittee recommends and the RUC approves the cover letter and survey instrument proposed by NASS.**

Ad Hoc Pre-Time Workgroup

Doctor Brenda Lewis delivered the Ad Hoc Pre-Service Time Workgroup Report to the RUC detailing the two items discussed: 1.) Pre-service time workgroup background and 2.) Ad Hoc Pre-Service Time Workgroup's Mission.

Doctor Lewis reviewed with the current Pre-Service Time Workgroup the charges as directed by the RUC. The Workgroup will be tasked to further refine the pre-service time packages. The Workgroup will also address the issue of retroactive application of pre-service time packages.

Doctor Lewis reviewed the mission of the Ad Hoc Pre-Service Time Workgroup as detailed in the report. The Workgroup addressed one of the concerns raised by ACS was that the current pre-service time packages do not address a straightforward patient undergoing a straightforward procedure under general anesthetic. **To address the concern raised by the ACS, the Workgroup recommends and the RUC agrees to add the following language to the note section of the pre-service time document:**

Additional time may be justified for a straightforward patient undergoing a straightforward procedure (Package 1B), if the procedure is performed under general anesthesia and the surveys support additional pre-service time.

A second issue raised by ACS was a concern that the pre-services packages that currently exist may not allow for specialties to support additional time when complex procedures require review of pathology reports and extensive imaging that is imperative to the operation. **The Workgroup recommends and the RUC agrees with addition of the following language which currently accompanies the pre-service time package instructions:**

"The Workgroup allows additional time if justified by the specialty society. The Workgroup believed additional increments of 15 minutes for TEE, Invasive monitoring , complex positioning, or extensive data review (reports or imaging studies as examples) may be appropriate for some procedures."

Furthermore, the Workgroup determined that until there is more data from RUC recommendations utilizing the pre-service time packages, making RUC policy to address the retroactive application of the new pre-service time packages to the entire RBRVS issue would be premature. The Workgroup recommends that it will address this issue after the fourth Five-Year Review when a few years of data have been collected and can be statistically reviewed by the Workgroup. **However, in the interim, the Workgroup recommends and the RUC agrees that services that have utilized the pre-service time packages be flagged in the RUC database.**

The RUC approved the Research Subcommittee and Ad Hoc Pre-Time Workgroup reports and they are attached to these minutes.

XIII. PLI Workgroup (Tab 36)

Peter Smith, MD, reported on the meeting with CMS and the two former PLI Workgroup Chairman. Doctor Smith indicated that the following issues were discussed with CMS at this meeting:

- The PLI technical component methodology and the current lack of existence of separate liability insurance for technical staff;
- The collection of premium data by the contractor, especially the concern to include all top high risk specialties; (neurosurgery, obstetrics/gynecology and cardiothoracic surgery) as well as health care professionals data;
- Previously recommended Maxillofacial crosswalks;
- Utilizing the RUC low volume (< 100) dominant specialty recommendations; and
- Utilizing current premium data (PIAA submitted data).

Doctor Smith indicated that his impression was that significant progress was made with the RUC's recommendations to CMS. CMS indicated basic agreement with the issues. The agency

has charged their contractor to specifically look for PLI evidence for technical staff as well as collect publicly available premium data for all specialties. The Agency indicated that they may address the maxillofacial crosswalk in the next *Proposed Rule*. Additionally, the Agency requested that the RUC resubmit their dominant specialty recommendations for low volume codes for consideration in proposed rulemaking.

As a result of the meeting with CMS, AMA staff identified 1,839 codes with frequency less than 100, based on 2007 Medicare utilization data. These codes were sent out to all specialty societies for comment to indicate who is the dominant specialty performing these services. These data were compiled and adjudicated with the previous 2006 recommendations, current utilization data and specialty society recommendations. The RUC reviewed all 1,839 assignments and by consensus recommends a dominant specialty assignment for each code.

Doctor Smith indicated that codes 99185 and 99186 were deleted from the screen as they have 0.00 work RVUs. However, the PLI workgroup did note that these codes incorrectly have PLI RVUs. The RUC recommends that the PLI RVUs for codes 99185 and 99186 should be 0.00.

The RUC dominant specialty recommendations for low volume codes are attached to this report and will be forwarded to CMS following this meeting.

The RUC approved the PLI Workgroup report and it is attached to these minutes.

XIV. HCPAC Review Board (Tab 37)

Lloyd Smith, DPM, informed the RUC that the HCPAC did not review CPT code 76880 *Ultrasound, extremity, nonvascular, real time with image documentation*. The Five-Year Review Identification Workgroup as part of its CMS-initiated 114 Fastest Growing Procedures screen identified this code. The American Podiatric Medical Association (APMA) rescinded its level of interest, as it stated that podiatrists are not the dominant specialty performing this service. The Workgroup identified that this services is predominantly provided by podiatry in the office setting, but is performed by diagnostic radiologists primarily in the facility setting. The HCPAC understands that the RUC Five-Year Review Identification Workgroup has recommended a joint CPT/RUC Workgroup review this and other services that utilize significantly less expensive technology than originally valued (eg, ultrasound room v. handheld ultrasound).

CMS Request: Relative Value Recommendations for CPT 2010:
Dr. Smith also informed the RUC that the HCPAC reviewed two speech-language pathology services codes.

On July 15 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech language pathologists may independently report services they provide to Medicare patients. Starting in July 2009, speech language pathologists will be able to bill Medicare as private practitioners.

On October 9, 2008, the American Speech-Language-Hearing Association (ASHA) sent a request to CMS that in light of the recent legislation the services of speech language pathologists be based on professional work values and not through the practice expense component. CMS requested that the RUC review the speech language codes for professional work as requested by ASHA. ASHA indicated that it will survey the 13 speech language pathology codes over the course of the next couple of meetings.

92611

The HCPAC reviewed the American Speech-Language-Hearing Association (ASHA) recommendation for 92611 *Motion fluoroscopic evaluation of swallowing function by cine or video recording.* The HCPAC recognized that since this speech language pathology service is converting from practice expense only inputs to work, that survey respondents had limited reference services to identify with. The HCPAC reviewed the pre-service time and determined that 7 minutes of pre-service time appropriately accounted for the time required to review the patients medical records, review the patient's history, prepare the barium liquids, prepare items of different consistencies and dress in the appropriate radiation deterrent gowns. The HCPAC reviewed the intra-service time and determined that 30 minutes appropriately accounted for the time to feed patients the numerous substances while watching the video fluoroscopy and make determinations on the subsequent liquid consistencies to utilize and patient postures employ. The HCPAC reviewed the immediate post-service time and recommended reducing the survey respondents and specialty society recommended time from 15 minutes to 10 minutes. The HCPAC determined that 10 minutes appropriately accounts for time required discussing findings with the patient/family, writing a report and communicating necessary information with the referring physician.

The HCPAC compared 92611 to 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-service, 30 minutes intra-service, and 8 minute post-service time) and 92602 *Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming* (work RVU = 1.30, 5 minutes pre-service, 50 minutes intra-service, and 10 minutes immediate post-service time). The HCPAC determined that 92611 is more intense than 97001 and 92602 as more management and following strategy determination is required.

The HCPAC also compared 92611 to code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.34, pre-service time = 4 minutes, intra-service time = 20 minutes and immediate post-service time = 5 minutes), and determined that the survey 25th percentile work RVU of 1.34 is exactly the same as 99203 and appropriately accounts for the work required to perform this service. **The HCPAC recommends a work RVU of 1.34, 7 minutes per-service time, 30 minutes intra-service time, and 10 minutes immediate post-service time for code 92611.**

Practice Expense

The HCPAC recommends removing the previous speech language pathologist's time from the practice expense inputs as well as replacing outdated recording output VHS tape with a DVD for the non-facility setting for code 92611.

92526

The HCPAC reviewed code 92526 *Treatment of swallowing dysfunction and/or oral function for feeding.* After a robust discussion of the intra-service work and episodes of therapy, the HCPAC recommends postponing recommending a work value for this service until additional frequency data is gathered and the RUC has reviewed the evaluation code, 92527 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech*, associated with this treatment code.

Other Issues:

Dr. Smith also indicated that the first term for the HCPAC Co-Chair and Alternate Co-Chair will conclude May 31, 2009. AMA Staff will be requesting nominations following this meeting and voting for these seats will occur at the April 2009 HCPAC meeting. Dr. Smith indicated that he and Emily Hill are eligible to serve a second 2-year term.

The RUC approved the HCPAC Review Board report and it is attached to these minutes.

XV. Five-Year Review Identification Workgroup (Tab 38)

Barbara Levy, MD provided the report of the Five-Year Review Identification Workgroup to the RUC. Doctor Levy presented the Workgroup's recommendations regarding the 32 codes originally recommended to be surveyed based on the Workgroup's review of each service in October 2008. In order to provide a complete and timely response to CMS, the Workgroup recommended and the RUC agreed that for any service where a survey is recommended, the survey be conducted and recommendations presented to the RUC at the October 2009 RUC meeting. However, the RUC would welcome surveys by April 2009 and would understand if some specialties (e.g., radiology) choose to split their codes between April 2009, October 2009, and February 2010. **The RUC recommends that for all recommendations to survey, except where otherwise stated, that the survey be conducted and RVU recommendations be presented in October 2009, allowing for April 2009 presentations if desired and requiring that all issues be presented no later than February 2010.**

The RUC also noted that a request to survey does not imply that an increase in utilization automatically translates to misvaluation. Rather, many of these codes have never been validated by the RUC and have now been presented to the RUC via multiple screens. **The RUC approved all recommendations of the Workgroup regarding the 32 Codes that May Need to Be Surveyed.**

Doctor Levy next discussed the recommendations of the Workgroup regarding a group of services that required more complete historical data. These services were deferred to this meeting to allow staff time to collect the requested data. **The RUC approved the recommendations of the Workgroup regarding Services Requiring Historical Data.**

Doctor Levy next discussed several services that were deferred to allow specialties to acquire additional data and present it to the Workgroup. **The RUC approved the recommendations of the Workgroup regarding these services.**

The Workgroup reviewed a request regarding the RUC's recommendation for the specialty societies to develop a coding change proposal to create a Category I CPT code to describe the work performed in G0181. Several specialties informed the RUC that such an action would be unnecessary as a Category I CPT code describing the work of G0181 already exists, 99375. **As such, the RUC rescinds it original recommendation and instead recommends that G0181 be removed from this screen.**

The RUC approved the recommendations of the Workgroup regarding Codes that Require Additional Information from Specialty.

Doctor Levy presented an overview of the Workgroup's discussion regarding "small-box" technologies emanating from discussion of APMA's rescission of a level of interest in surveying 76880. The APMA noted that the physician work component of 76880 is more commonly performed by Diagnostic Radiology. According to the 2007 Medicare utilization data, the physician work component of 76880 (which is a PC/TC split) is reported 32 percent of the time by Podiatry and 44 percent by Diagnostic Radiology. However, Podiatry is the dominant provider of the technical component of the code, providing slightly more than 50 percent of the

technical component. The ACR indicated an interest in the service. The ACR noted that the availability of handheld ultrasound equipment has enabled podiatry and other specialties to perform this and other similar procedures within their offices, which is driving the increase in utilization. The Workgroup noted that value of 76880 includes the ultrasound room, which is priced significantly higher than the handheld device. The Workgroup agreed that this is an issue that may need to be addressed through either CPT changes and/or significant changes in the practice expense and possibly work. **The RUC recommends the creation of a joint CPT and RUC workgroup to research this issue to identify similar services and develop recommendations to appropriately describe and/or address the valuation of these services.**

Doctor Levy reported that the Workgroup has established a timeline for review of the nine Harvard-valued codes with utilization greater than 1,000,000 and their respective families. **The RUC approved the recommendations of the Workgroup regarding a timeline for review of these services.**

Doctor Levy updated the RUC on several services that the Workgroup and RUC had asked CMS to investigate. CMS indicated an understanding of this recommendation and assured the Workgroup that the Agency will be investigating each of these issues. **The RUC approved the recommendation of the Workgroup that the evaluations of 76790, 94450, 94014, 94015, 94016, G0237, and G0238 are complete upon the referral of the RUC's articulated concerns to CMS.**

Doctor Levy discussed a preliminary timeline for initiation and facilitation of the fourth Five-Year Review. The Workgroup discussed the timeline and will recommend a timeline, general procedures, and specific issues for review to the RUC for consideration at the April 2009 RUC meeting.

The RUC approved the Five-Year Review Identification Workgroup report and it is attached to these minutes.

XVI. Other Issues

23-Hour Stay Issue

The RUC entertained a discussion of the 23+-hour stay issue. That is, where patients stay overnight following a procedure, but are not admitted as inpatients. The RUC confronted several examples where physicians indicate an evaluation and management procedure on the evening of the procedure (99231) and another visit on the morning after the procedure in conjunction with discharge management. According to RUC convention, the physician work would otherwise not include a 99231 or a full 99238 discharge day management procedure in a service that was predominately performed in the outpatient setting. The RUC agreed that if physicians are performing this work, it should be reflected within the valuation of the service despite RUC convention. In order to capture the work, the RUC considered several options for a work proxy to reflect this 23+-hour observation stay. These options for a work proxy included other E/M services, such as 99217 or 99218, or adjusting the valuation or fractioning of hospital visits to account for this work. **The RUC did not reach a consensus and referred the issue for further discussion to the Research Subcommittee.**

The meeting adjourned on Saturday January 31, 2009 at 5:30 p.m.

Subcutaneous Recommendations

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
215X0	P7	090	3.88	The RUC reviewed the survey data for CPT code 215X0 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm and compared it with its reference code 11642 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm (Work RVU=2.57) and MPC code 11644 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm (Work RVU=4.29). The RUC noted that the surveyed code had less intra-service time than the MPC code, 35 minutes and 45 minutes, respectively and that the surveyed code had more intra-service time that the reference code, 35 minutes and 25 minutes, respectively. Further, the RUC noted that the surveyed code required more technical skill, mental effort and judgment to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 3.88 RVUs for 215X0, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 215X0.
215X1	P8	090	6.41	The RUC reviewed the survey data for CPT code 215X1 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater and compared it with its reference code 38510 Biopsy or excision of lymph node(s); open, deep cervical node(s) (Work RVU=6.69) and MPC code 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular (Work RVU=5.51). The RUC noted that the surveyed code had more total time than the MPC code, 194 minutes and 187 minutes, respectively. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Further, the RUC noted that the surveyed code required less psychological stress and less urgency of decision making than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 6.41 RVUs for 215X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 6.41 Work RVUs for 215X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
21930	P13	090	4.86	The RUC reviewed the survey data for CPT code 21930 Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm and compared it with its reference code, MPC code 11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm (Work RVU=4.97). The RUC noted that the surveyed code and the reference code had similar total service times, 165 minutes and 153 minutes, respectively. The RUC noted that the surveyed code required more technical skill to perform and creates more psychological stress than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code the RUC recommends 4.86 RVUs for 21930, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 4.86 Work RVUs for 21930.
219X1	P14	090	6.80	The RUC reviewed the survey data for CPT code 219X1 Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater and compared it with its reference code, 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) (Work RVU=6.35). The RUC noted that the surveyed code had more intra-service time than the reference code, 60 minutes and 45 minutes, respectively and more total service time than the reference code, 206 minutes and 178 minutes respectively. Further, the RUC noted that the surveyed code requires more physical effort to perform and creates more psychological stress than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.80 RVUs for 219X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 6.80 Work RVUs for 219X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
230X0	P25	090	4.13	The RUC reviewed the survey data for CPT code 230X0 Excision, soft tissue tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm and compared it with its reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47). The RUC noted that the surveyed code had more total service time that the reference code, 142 minutes and 113 minutes, respectively. Further, the RUC noted that the surveyed code required more technical skill, mental effort and judgment to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 230X0, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 4.13 Work RVUs for 230X0.
230X1	P26	090	5.83	The RUC reviewed the survey data for CPT code 230X1 Excision, soft tissue tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90). The RUC noted that the surveyed code and the reference code had similar total service times, 191 minutes and 181 minutes respectively. Further, the RUC noted that the surveyed code and the reference code had similar intensity and complexity measurements with the reference code causing slightly more psychological stress. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code, the RUC recommends 5.83 RVUs for 230X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.83 Work RVUs for 230X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
240X0	P34	090	4.16	The RUC reviewed the survey data for CPT code 240X0 Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm and compared it with its reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47). The RUC noted that the surveyed code had more total service time than the reference code, 142 minutes and 113 minutes respectively. Further, the RUC noted that the surveyed code required more mental effort, judgment, technical skill and physicial effort to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code, the RUC recommends 4.16 RVUs for 240X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 4.16 Work RVUs for 240X0.
240X1	P35	090	5.62	The RUC reviewed the survey data for CPT code 240X1 Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90) and MPC code 11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm (Work RVU=4.97). Despite similar intensity and complexity measurements, the RUC noted that the surveyed code had less intra-service time as compared to the reference code, 45 minutes and 50 minutes, respectively and that the surveyed code had more total service time than the MPC code, 183 minutes and 153 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 5.62 RVUs for 240X1, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.62 Work RVUs for 240X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
250X0	P42	090	3.88	The RUC reviewed the survey data for CPT code 250X0 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm and compared it with its reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47). The RUC noted that the surveyed code had more total service time than the reference code, 137 minutes and 113 minutes respectively. Further, the RUC noted that the surveyed code required more technical skill and overall was a more intense procedure to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 250X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 250X0.
250X1	P43	090	5.83	The RUC reviewed the survey data for CPT code 250X1 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90). The RUC noted that the surveyed code and the reference code had similar total service times, 178 minutes and 181 minutes respectively. Further, the RUC noted that the surveyed code and the reference code had very similar intensity and complexity measurement with the reference code requiring slightly more physical effort to perform in comparison to the surveyed code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 5.83 RVUs for 250X1, which is a value between the 25th percentile and the surveyed median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.83 Work RVUs for 250X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
261X0	P49	090	3.88	The RUC reviewed the survey data for CPT code 261X0 Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90). The RUC noted that the surveyed code had less total service time than the reference code, 137 minutes and 181 minutes respectively. Further, the RUC noted that the surveyed code requires less technical skill, physical effort and overall was a less intense procedure to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 261X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 261X0.
261X1	P50	090	5.34	The RUC reviewed the survey data for CPT code 261X1Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater and compared it with its reference code, 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90) and MPC code 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular (work RVU=5.51). Although, the intensity and complexity measures of the surveyed code and the reference code are the same, the RUC noted that the surveyed code had less intra-service time than the reference code and the MPC code, 40 minutes, 50 minutes and 60 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and the MPC code, the RUC recommends 5.34 RVUs for 261X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.34 Work RVUs for 261X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
270X0	P58	090	4.86	The RUC reviewed the survey data for CPT code 270X0 Excision, tumor, soft tissue of pelvis and hip area, subcutaneous tissue; less than 3 cm and compared it with its reference code, 46040 Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)(Work RVU=5.26) and MPC code 11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm (work RVU=4.97). The RUC noted that the surveyed code had less total service time than the reference code, 160 minutes and 184 minutes, respectively and that the surveyed code had similar total service time that the reference code, 160 minutes and 153 minutes, respectively. Further, the RUC noted that the surveyed code required less mental effort and judgment to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 4.86 RVUs for 270X0, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 4.86 Work RVUs for 270X0.
270X1	P59	090	6.80	The RUC reviewed the survey data for CPT code 270X1 Excision, tumor, soft tissue of pelvis and hip area, subcutaneous tissue; 3 cm or greater and compared it with its reference code, 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) (Work RVU=6.35). The RUC noted that the surveyed code had more intra-service time than the reference code, 60 minutes and 45 minutes, respectively and more total service time than the reference code, 206 minutes and 178 minutes respectively. Further, the RUC noted that the surveyed code required more technical skill, physical effort to perform and creates more psychological stress than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.80 RVUs for 270X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 6.80 Work RVUs for 270X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
273X0	P68	090	3.88	The RUC reviewed the survey data for CPT code 273X0 Excision, tumor, soft tissue of thigh or knee area;, subcutaneous; less than 3 cm and compared it with its reference code 11622 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm(Work RVU=2.36). The RUC noted that the surveyed code had more total service time than the reference code, 140 minutes and 87 minutes respectively. Further, the RUC noted that the surveyed code requires more technical skill and overall was a more intense procedure to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 273X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 273X0.
273X1	P69	090	5.83	The RUC reviewed the survey data for CPT code 273X1Excision, tumor, soft tissue of thigh or knee area;, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90). The RUC noted that the surveyed code and the reference code had the same total service times, 181 minutes. Further, the RUC noted that the surveyed code and the reference code had similar intensity and complexity measurements with the reference code requiring slightly more technical skill and physical effort to perform in comparison to the surveyed code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 5.83 RVUs for 273X1, which is a value between the 25th percentile and the surveyed median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.83 Work RVUs for 273X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
276X0	P77	090	3.88	The RUC reviewed the survey data for CPT code 276X0 Excision, tumor, soft tissue of leg or ankle area;, subcutaneous; less than 3 cm and compared it with its reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47). The RUC noted that the surveyed code had more total service time than the reference code, 137 minutes and 113 minutes respectively. Further, the RUC noted that the surveyed code required more mental effort and judgment and overall was a more intense procedure to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 276X0, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 276X0.
276X1	P78	090	5.83	The RUC reviewed the survey data for CPT code 276X1 Excision, tumor, soft tissue of leg or ankle area;, subcutaneous; 3 cm or greater and compared it with its reference code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate) (Work RVU=5.90) and MPC code 11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm (Work RVU=4.97). The RUC noted that the surveyed code and the reference codes had very similar total service times, 183 minutes and 181 minutes, respectively and that the surveyed code had more total service time than the MPC code, 183 minutes and 153 minutes, respectively. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and MPC code, the RUC recommends 5.83 RVUs for 276X1, which is a value below the surveyed 25th percentile. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.83 Work RVUs for 276X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
280X0	P86	090	3.88	The RUC reviewed the survey data for CPT code 280X0 Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm and compared it with its reference code 11422 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm (Work RVU=1.65). The RUC noted that the surveyed code had significantly more total service time than the reference code, 138 minutes and 56 minutes respectively. Further, the RUC noted that the surveyed code required more technical skill and physical effort to perform than the reference code. In addition the RUC compared the surveyed code to another reference code 11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm (Work RVU=3.47) and noted that the surveyed code has more total service time than this reference code, 138 minutes and 113 minutes respectively. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 3.88 RVUs for 280X0, which is a value between the 25th percentile and the surveyed median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 3.88 Work RVUs for 280X0.
280X1	P87	090	5.34	The RUC reviewed the survey data for CPT code 280X1 Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater and compared it with its reference code, 28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint (Work RVU=8.11). The RUC noted that the surveyed code had less total-service time than the reference code, 153 minutes and 197 minutes, respectively. Further, the RUC noted that the surveyed code required more technical skill, physical effort to perform and creates more psychological stress to perform than the reference code. Further, the RUC compared the surveyed code to MPC code 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular (Work RVU=5.51) and noted that the surveyed code has significantly more total time than the surveyed code, 187 minutes and 153 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 5.34 RVUs for 280X1, which is a value in between the 25th percentile and survey median. As mentioned in the overall rationale, the RUC agreed that the subcutaneous codes should be work neutral, therefore, the RUC recommended value takes into account the 2.88% reduction applied to all of the subcutaneous codes. The RUC recommends 5.34 Work RVUs for 280X1.

Subfascial Recommendations

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
215X2	P9	090	7.53	The RUC reviewed the survey data for CPT code 215X2 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 38510 Biopsy or excision of lymph node(s); open, deep cervical node(s) (Work RVU=6.69). The RUC noted that the surveyed code has more total service time than the reference code, 234 minutes and 152 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment and technical skill to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 7.53 RVUs for 215X2, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.53 Work RVUs for 215X2.
215X3	P10	090	11.00	The RUC reviewed the survey data for CPT code 215X3 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 38700 Suprahyoid lymphadenectomy (Work RVU=12.68). The RUC noted that although the surveyed code and the reference code have the same intra-service time, 90 minutes, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip (Work RVU=11.03) as the surveyed code and 27822 reference code have the same intra-service time, 90 minutes and similar intensity of work. Due to these comparisons between the surveyed code and the 27822 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends the survey 25th percentile, 11.00 RVUs for 215X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 11.00 Work RVUs for 215X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
22900	P21	090	8.21	The RUC reviewed the survey data for CPT code 22900 Excision, tumor, soft tissue of abdominal wall tumor, subfascial (eg, desmoid intramuscular); less than 5 cm and compared it with its reference code 49505 Repair initial inguinal hernia, age 5 years or older; reducible (Work RVU=7.88). The RUC reviewed the survey data and agreed with the specialty society that a hospital visit and full day discharge visit were appropriate as majority of survey respondents who stated that they typically perform this procedure in the hospital stated that the patient is kept overnight or admitted. In addition, the RUC noted that the surveyed code as compared to the reference code has more total service time (244 minutes and 198 minutes). Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 8.21 RVUs for 22900, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 8.21 Work RVUs for 22900.
229X2	P22	090	10.00	The RUC reviewed the survey data for CPT code 229X2 Excision, tumor, soft tissue of abdominal wall tumor, subfascial (eg, desmoid intramuscular); 5 cm or greater and compared it with its reference code 49560 Repair initial incisional or ventral hernia; reducible (Work RVU=11.84). The RUC noted that although the surveyed code and the reference code have the same intra-service time, 90 minutes, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors (Work RVU=9.89). The RUC agreed that 25115 was a better reference because the surveyed code and 25115 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 90 minutes and 3.) the 25115 reference code has slightly less total service time as compared to the surveyed code, 257 minutes and 284 minutes. Due to these comparisons between the surveyed code and the 25115 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 10.00 RVUs, a value below the surveyed 25th percentile, for 229X2. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 10.00 Work RVUs for 229X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
230X2	P27	090	7.28	The RUC reviewed the survey data for CPT code 230X2 Excision, tumor, soft tissue of tumor shoulder area; deep, subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 13132 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm (Work RVU=6.48). The RUC noted that the surveyed code as compared to the reference code has more intra-service time (60 minutes and 45 minutes) and more total service time (221 minutes and 136 minutes). Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 7.28 RVUs for 230X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.28 Work RVUs for 230X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
230X3	P28	090	10.00	The RUC reviewed the survey data for CPT code 230X3 Excision, tumor, soft tissue of tumor shoulder area; deep, subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 29828 Arthroscopy, shoulder, surgical; biceps tenodesis (Work RVU=13.00). The RUC determined that the pre-service time package selected by the specialty society did not accurately reflect the pre-service time to perform the procedure. Therefore, the RUC modified the pre-service package associated with this service to pre-service time package three as the RUC agreed that the vignette described a more staightforward patient. Further, the RUC noted that although the surveyed code and the reference code have the same intra-service time, 75 minutes, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula (Work RVU=10.01). The RUC agreed that 27832 was a better reference because the surveyed code and 27832 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 75 minutes and 3.) the 27832 reference code has very similar total service times as compared to the surveyed code, 301 minutes and 297 minutes. Due to these comparisons between the surveyed code and the 27832 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends the surveyed 25th percentile,10.00 RVUs, for 230X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 10.00 Work RVUs for 230X3.
240X2	P36	090	7.28	The RUC reviewed the survey data for CPT code 240X2 Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each (Work RVU=6.81). The RUC noted that the surveyed code as compared to the reference code has more intra-service time (60 minutes and 40 minutes) and more total service time (229 minutes and 191 minutes). Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 7.28 RVUs for 240X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.28 Work RVUs for 240X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
240X3	P37	090	10.00	The RUC reviewed the survey data for CPT code 240X3 Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC determined that the pre-service time package selected by the specialty society did not accurately reflect the pre-service time to perform the procedure. Therefore, the RUC modified the pre-service package associated with this service to pre-service time package three as the RUC agreed that the vignette described a more straightforward patient. Further, the RUC noted that although the surveyed code has less total service time than the reference code, 295 minutes and 358 minutes, respectively, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula (Work RVU=10.01). The RUC agreed that 27832 was a better reference because the surveyed code and 27832 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 75 minutes and 3.) the 27832 reference code has very similar total service times as compared to the surveyed code, 301 minutes and 295 minutes. Due to these comparisons between the surveyed code and the 27832 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 10.00 RVUs, a value below the surveyed 25th percentile, for 240X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 10.00 Work RVUs for 240X3.
250X2	P44	090	6.61	The RUC reviewed the survey data for CPT code 250X2 Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm and compared it with its reference code 25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each (Work RVU=6.81). The RUC noted that the surveyed code and the reference code have very similar intra-service times (45 minutes and 40 minutes, respectively and total service times (206 minutes and 191 minutes, respectively) Further, the RUC noted that the surveyed code and the reference code have very similar intensity and complexity measurements. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.61 RVUs for 250X2, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 6.61 Work RVUs for 250X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
250X3	P45	090	7.00	The RUC reviewed the survey data for CPT code 250X3 Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater and compared it with its reference code 25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors (Work RVU=9.89). The RUC noted that the surveyed code has less intra-service time than the reference code, 60 minutes and 90 minutes, respectively. During its discussion, the RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 38520 Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad (Work RVU=6.95). The RUC agreed that 38520 was a better reference because the surveyed code and the 38520 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 60 minutes and 3.) the 38520 reference code has slightly less total service time as compared to the surveyed code, 193 minutes and 221 minutes. Due to these comparisons between the surveyed code and the 38520 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 7.00 RVUs, a value below the surveyed 25th percentile, for 250X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.00 Work RVUs for 250X3.
261X2	P51	090	6.61	The RUC reviewed the survey data for CPT code 261X2 Excision, tumor, soft tissue, or vascular malformation, soft tissue of hand or finger; subfascial (eg, intramuscular); less than 1.5 cm and compared it with its reference code 25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each (Work RVU=6.81). The RUC noted that the surveyed code and the reference code have very similar intra-service times (45 minutes and 40 minutes, respectively and total service times (201 minutes and 191 minutes, respectively) Further, the RUC noted that the surveyed code and the reference code have very similar intensity and complexity measurements. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.61 RVUs for 261X2, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 6.61 Work RVUs for 261X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
261X3	P52	090	7.00	The RUC reviewed the survey data for CPT code 280X3 Excision, tumor, soft tissue, or vascular malformation, soft tissue of hand or finger; subfascial (eg, intramuscular); 1.5 cm or greater and compared it with its reference code 25109 Excision of tendon, forearm and/or wrist, flexor or extensor, each (Work RVU=6.81). The RUC noted that the surveyed code as compared to the reference code has more intra-service time (58 minutes and 40 minutes, respectively and total service time (214 minutes and 191 minutes, respectively). Furthermore the RUC noted that the surveyed code requires greater mental effort and judgment to perform than the surveyed code. However, the RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Due to these comparisons between the surveyed code and the reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 7.00 RVUs, a value slightly higher than the surveyed 25th percentile for 261X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.00 Work RVUs for 261X3.
270X2	P60	090	8.74	The RUC reviewed the survey data for CPT code 270X2 Excision, tumor, soft tissue of pelvis and hip area subfascial (eg, intramuscular); less than 5 cm and compared it with MPC code 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less (Work RVU=8.44). The RUC noted that when comparing the surveyed code to MPC code 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less (Work RVU=8.44), the surveyed code has more total service time than this MPC reference code, 288 minutes and 223 minutes . Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 8.74 RVUs for 270X2, which is a value between 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 8.74 Work RVUs for 270X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
270X3	P61	090	11.00	The RUC reviewed the survey data for CPT code 270X3 Excision, tumor, soft tissue of pelvis and hip area subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 47100 Biopsy of liver, wedge (Work RVU=12.78). The RUC noted that although the surveyed code has less total service time than the reference code, 320 minutes and 345 minutes, respectively. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs were reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip (Work RVU=11.03) as the surveyed code and 27822 reference code have the same intra-service time, 90 minutes and similar intensity of work. Due to these comparisons between the surveyed code and the 27822 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends the surveyed 25th percentile of 11.00 RVUs for 270X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 11.00 Work RVUs for 270X3.
273X2	P70	090	8.74	The RUC reviewed the survey data for CPT code 273X2 Excision, tumor, soft tissue of thigh or knee area subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC noted that the surveyed code and the reference code have similar intensity and complexity measures and the surveyed code as compared to the reference code has comparable total service time (261 minutes and 281 minutes). The RUC noted that when comparing the surveyed code to MPC code 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less (Work RVU=8.44), the surveyed code has more total service time than this MPC reference code, 261 minutes and 223 minutes . Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 8.74 RVUs for 273X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 8.74 Work RVUs for 273X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
273X3	P71	090	11.00	The RUC reviewed the survey data for CPT code 273X3 Excision, tumor, soft tissue of thigh or knee area subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 27880 Amputation, leg, through tibia and fibula; (Work RVU=15.24). The RUC noted that although the surveyed code has less total service time than the reference code, 310 minutes and 423 minutes, respectively, and agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip (Work RVU=11.03) as the surveyed code and 27822 reference code have the same intra-service time, 90 minutes and similar intensity of work. Due to these comparisons between the surveyed code and the 27822 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 11.00 RVUs, a value below the surveyed 25th percentile, for 273X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 11.00 Work RVUs for 273X3.
276X2	P79	090	6.80	The RUC reviewed the survey data for CPT code 276X2 Excision, tumor, soft tissue of leg or ankle area subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC noted that the surveyed code has less total service time than the reference code, 225 minutes and 281 minutes, respectively. Further, the RUC noted that the reference code causes more psychological stress to perform than the surveyed code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.80 RVUs for 276X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 6.80 Work RVUs for 276X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
276X3	P80	090	10.00	The RUC reviewed the survey data for CPT code 276X3 Excision, tumor, soft tissue of leg or ankle area subfascial (eg, intramuscular); 5 cm or greater and compared it with its reference code 28299 Excision, tumor, soft tissue of leg or ankle area subfascial (eg, intramuscular); (Work RVU=11.39). When reviewing the pre-service time packages, the RUC determined that the pre-service time package selected by the specialty society did not accurately reflect the pre-service time to perform the procedure. Therefore, the RUC modified the pre-service package associated with this service to pre-service time package three as the RUC agreed that the vignette described a more staightforward patient. Further, the RUC noted that although the surveyed code has less intra-service time than the reference code, 70 minutes and 90 minutes respectively, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 27832 Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula (Work RVU=10.01). The RUC agreed that 27832 was a better reference because the surveyed code and 27832 reference code have 1.) similar intensities of work, 2.) the similar intra-service times, 70 minutes and 75 minutes and 3.) the 27832 reference code has very similar total service times as compared to the surveyed code, 301 minutes and 293 minutes. Due to these comparisons between the surveyed code and the 27832 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends the surveyed 25th percentile, 10.00 RVUs, for 276X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 10.00 Work RVUs for 276X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
280X2	P88	090	5.34	The RUC reviewed the survey data for CPT code 280X2 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm and compared it with its reference code 13121 Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm (Work RVU=4.36). The RUC noted that the surveyed code has more total service time than the reference code, 169 minutes and 117 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment and technical skill to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 5.34 RVUs for 280X2, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 5.34 Work RVUs for 280X2.
280X3	P89	090	7.00	The RUC reviewed the survey data for CPT code 280X3 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater and compared it with its reference code 29891 Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect (Work RVU=9.47). The RUC noted that although the surveyed code has less total service time than the reference code, 217 minutes and 227 minutes, respectively, the RUC agreed that this was a poor reference code. The RUC determined that as the primary difference between the small and large subfascial tumor codes is the difference in the intra-service time, the specialty requested RVUs needed to be reduced to more accurately reflect the work associated with this service and to preserve the rank order with the small subfascial family of codes. Therefore, the RUC agreed that a better reference code would be 38520 Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad (Work RVU=6.95). The RUC agreed that 38520 was a better reference because the surveyed code and the 38520 reference code have 1.) similar intensities of work, 2.) the same intra-service time, 60 minutes and 3.) the 38520 reference code has slightly less total service time as compared to the surveyed code, 193 minutes and 217 minutes. Due to these comparisons between the surveyed code and the 38520 reference code and to maintain relativity with the small subfascial excision codes, the RUC recommends 7.00 RVUs, a value between the 25th percentile and surveyed median, for 280X3. As described in the overall rationale, the RUC agreed that in order to maintain relativity with the recommendations for the subcutaneous codes, the recommendations for the subfascial codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the subfascial codes. The RUC recommends 7.00 RVUs for Work 280X3.

Radical Recommendations

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
21015	P5	090	9.71	The RUC reviewed the survey data for CPT code 21015 Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm and compared it with its reference code 38700 Suprahyoid lymphadenectomy (Work RVU=12.68). The RUC noted that the surveyed code as compared to the reference code has less intra service time (75 minutes and 90 minutes, respectively) and less total service time (277 minutes and 300 minutes). Further, the RUC noted that the surveyed code overall is a less intense procedure to perform than the reference code. In addition, the RUC compared the surveyed code to MPC code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC noted that the surveyed code in comparison to the MPC code has similar total service times, 277 minutes and 281 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and the MPC code, the RUC recommends 9.71 RVUs for 21015, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 9.71 Work RVUs for 21015.
210X5	P6	090	15.05	The RUC reviewed the survey data for CPT code 210X5 Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; 2 cm or greater and compared it with its reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code has slightly less total service time as compared to the reference code, 398 minutes and 407 minutes, respectively. In addition, the RUC compared the surveyed code to another reference code 27880 Amputation, leg, through tibia and fibula; (Work RVU=15.24). The RUC noted that the surveyed code as compared to the reference code has very similar total service time (398 minutes and 400 minutes). Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 15.05 RVUs for 210X5, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.05 Work RVUs for 210X5.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
21557	P11	090	14.57	The RUC reviewed the survey data for CPT code 21557 Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm and compared it with its reference code 38700 Suprahyoid lymphadenectomy (Work RVU=12.68). The RUC noted that the surveyed code as compared to the reference code has more intra-service time, 113 minutes and 90 minutes, respectively and more total service time than the reference code, 398 minutes and 300 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment and more physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 14.57 RVUs for 21557, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 14.57 Work RVUs for 21557.
215X4	P12	090	21.37	The RUC reviewed the survey data for CPT code 215X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; 5 cm or greater and compared it with reference code 15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk (Work RVU=19.62). The RUC noted that although the surveyed code and the reference code have similar intra-service times, 160 minutes and 163 minutes, respectively, the surveyed procedure requires significantly more mental effort and judgment, technical skill, and physical effort to perform as compared to the reference code. In addition, the RUC compared the surveyed code to MPC code 35656 Bypass graft, with other than vein; femoral-popliteal (Work RVU=20.39). The RUC noted that the surveyed code has more total service time as compared to the MPC code, 480 minutes and 447 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 21.37 RVUs for 215X4, which is a value between the 25th percentile and surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 21.37 Work RVUs for 215X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
21935	P17	090	15.54	The RUC reviewed the survey data for CPT code 21935 Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm and compared it with its reference code 27880 Amputation, leg, through tibia and fibula; (Work RVU=15.24). The RUC noted that the surveyed code as compared to the reference code has more intra service time (120 minutes and 80 minutes, respectively) and very similar total service time (408 minutes and 400 minutes). Further, the RUC noted that the surveyed code overall is a slightly more intense procedure to perform than the reference code. In addition, the RUC compared the surveyed code to another reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). The RUC noted that the surveyed code and the reference code have very similar total service times, 408 minutes and 407 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference codes, the RUC recommends 15.54 RVUs for 21935, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.54 Work RVUs for 21935.
219X4	P18	090	22.34	The RUC reviewed the survey data for CPT code 219X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; 5cm or greater and compared it with its reference code 49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less (Work RVU=20.00). The RUC noted that the surveyed code has more intra-service time than the reference code, 160 minutes and 120 minutes respectively and more total service time than the reference code, 510 minutes and 420 minutes, respectively . Further, the RUC noted that the surveyed code requires more mental effort and judgment, more technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 22.34 RVUs for 219X4, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 22.34 Work RVUs for 219X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
23077	P29	090	17.48	The RUC reviewed the survey data for CPT code 23077 Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; less than 5 cm and compared it with its reference code 23395 Muscle transfer, any type, shoulder or upper arm; single (Work RVU=18.29). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (140 minutes and 160 minutes, respectively). In addition, the RUC compared the surveyed code to another reference code 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); (Work RVU=17.21). The RUC noted that the surveyed code in comparison to the reference code has more intra-service time, 140 minutes and 120 minutes and more total service times, 433 minutes and 394 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 17.48 RVUs for 23077, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 17.48 Work RVUs for 23077.
230X4	P30	090	22.34	The RUC reviewed the survey data for CPT code 230X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; 5 cm or greater and compared it with reference code 44140 Colectomy, partial; with anastomosis (Work RVU=22.46). The RUC noted that the surveyed code and the reference code have very similar total service times, 490 minutes and 480 minutes, respectively. In addition, the RUC compared the surveyed code to MPC code 35656 Bypass graft, with other than vein; femoral-popliteal (Work RVU=20.39). The RUC noted that the surveyed code has more intra-service time than the MPC code, 180 minutes and 150 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 22.34 RVUs for 230X4, which is a value between the 25th percentile and surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 22.34 Work RVUs for 230X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
240X4	P38	090	15.54	The RUC reviewed the survey data for CPT code 240X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm and compared it with its reference code 23395 Muscle transfer, any type, shoulder or upper arm; single (Work RVU=18.29). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (120 minutes and 160 minutes, respectively). In addition, the RUC compared the surveyed code to another reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). The RUC noted that the surveyed code in comparison to the reference code has similar total service times, 405 minutes and 407 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference codes, the RUC recommends 15.54 RVUs for 240X4, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.54 Work RVUs for 240X4.
240X5	P39	090	20.40	The RUC reviewed the survey data for CPT code 240X5 Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; 5 cm or greater and compared it with reference code 44140 Colectomy, partial; with anastomosis (Work RVU=22.46). The RUC noted that the surveyed code has less total service time as compared to the reference code, 472 minutes and 480 minutes, respectively. In addition, the RUC compared the surveyed code to MPC code 35656 Bypass graft, with other than vein; femoral-popliteal (Work RVU=20.39). The RUC noted that the surveyed code and the MPC code have the same intra-service time, 150 minutes. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 20.40 RVUs for 240X5, which is a value between the 25th percentile and surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 20.40 Work RVUs for 240X5.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
25077	P46	090	12.75	The RUC reviewed the survey data for CPT code 25077 Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; less than 3 cm and compared it with its reference code 25515 Open treatment of radial shaft fracture, includes internal fixation, when performed (Work RVU=9.89). The RUC noted that the surveyed code as compared to the reference code has more intra-service time, 100 minutes and 90 minutes, respectively and more total service time than the reference code, 345 minutes and 257 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, more technical skill and overall is a much more intense procedure to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 12.75 RVUs for 25077, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 12.75 Work RVUs for 25077.
250X4	P47	090	17.48	The RUC reviewed the survey data for CPT code 250X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; 3 cm or greater and compared it with its reference code 24363 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) (Work RVU=22.47). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code has less total service time as compared to the reference code, 422 minutes and 466 minutes, respectively and less intra-service time, 120 minutes and 150 minutes respectively. In addition, the RUC compared the surveyed code to MPC code 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); (Work RVU=17.21). The RUC noted that the surveyed code as compared to the reference code has more total service time, 422 minutes and 394 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 17.48 RVUs for 250X4, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 17.48 Work RVUs for 250X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
26117	P53	090	9.95	The RUC reviewed the survey data for CPT code 26117 Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; less than 3 cm and compared it with its reference code 25447 Arthroplasty, interposition, intercarpal or carpometacarpal joints (Work RVU=10.95). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (75 minutes and 100 minutes, respectively). In addition, the RUC compared the surveyed code to MPC code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC noted that the surveyed code in comparison to the MPC code has more intra-service time, 75 minutes and 60 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and the MPC code, the RUC recommends 9.95 RVUs for 26117, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 9.95 Work RVUs for 26117.
261X4	P54	090	14.57	The RUC reviewed the survey data for CPT code 261X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; 3 cm or greater and compared it with its reference code 24363 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) (Work RVU=22.47). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (100 minutes and 150 minutes, respectively) and less total service time (368 minutes and 466 minutes). In addition, the RUC compared the surveyed code to another reference code 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments (Work RVU=14.12). The RUC noted that the surveyed code in comparison to this reference code has more total service time, 368 minutes and 358 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 14.57 RVUs for 261X4, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 14.57 Work RVUs for 261X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
270X4	P62	090	21.37	The RUC reviewed the survey data for CPT code 270X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; less than 5 cm and compared it with its reference code 47380 Ablation, open, of one or more liver tumor(s); radiofrequency (Work RVU=24.43). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (180 minutes and 200 minutes, respectively). In addition, the RUC compared the surveyed code to MPC code 35656 Bypass graft, with other than vein; femoral-popliteal (Work RVU=20.39). The RUC noted that the surveyed code in comparison to the MPC code has more intra-service time, 180 minutes and 150 minutes and more total service times, 496 minutes and 447 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 21.37 RVUs for 270X4, which is a value between the 25th percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 21.37 Work RVUs for 270X4.
270X5	P63	090	29.14	The RUC reviewed the survey data for CPT code 270X5 Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; 5 cm or greater and compared it with its reference code 27134 Revision of total hip arthroplasty; both components, with or without autograft or allograft (Work RVU=30.13). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less intra service time (220 minutes and 240 minutes, respectively). In addition, the RUC noted that the surveyed code in comparison to the reference code has similar total service times, 608 minutes and 617 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 29.14 RVUs for 270X5, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 29.14 Work RVUs for 270X5.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
273X4	P72	090	15.54	The RUC reviewed the survey data for CPT code 273X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; less than 5 cm and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less total service time (413 minutes and 469 minutes, respectively). In addition, the RUC compared the surveyed code to another reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). The RUC noted that the surveyed code in comparison to the reference code has similar total service times, 413 minutes and 407 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference codes, the RUC recommends 15.54 RVUs for 273X4, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.54 Work RVUs for 273X4.
273X5	P73	090	24.28	The RUC reviewed the survey data for CPT code 273X5 Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; 5cm or greater and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). The RUC noted that the surveyed code has more intra-service time than the reference code, 180 minutes and 124 minutes respectively and more total service time than the reference code, 550 minutes and 469 minutes, respectively . Further, the RUC noted that the surveyed code requires more mental effort and judgment, more technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 24.28 RVUs for 273X5, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 24.28 Work RVUs for 273X5.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
27615	P75	090	15.54	The RUC reviewed the survey data for CPT code 27615 Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm and compared it with its reference code 27880 Amputation, leg, through tibia and fibula; (Work RVU=15.24). The RUC noted that the surveyed code as compared to the reference code has more intra service time (120 minutes and 80 minutes, respectively) and very similar total service time (416 minutes and 400 minutes). Further, the RUC noted that the surveyed code overall is a slightly more intense procedure to perform than the reference code. In addition, the RUC compared the surveyed code to another reference code 41130 Glossectomy; hemiglossectomy (Work RVU=15.51). The RUC noted that the surveyed code and the reference code have similar total service times, 416 minutes and 407 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference codes, the RUC recommends 15.54 RVUs for 27615, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 15.54 Work RVUs for 27615.
2761X	P76	090	19.42	The RUC reviewed the survey data for CPT code 2761X Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; 5 cm or greater and compared it with reference code 15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk(Work RVU=19.62). The RUC noted that the surveyed code has less total service time as compared to the reference code, 463 minutes and 524 minutes, respectively. In addition, the RUC compared the surveyed code to MPC code 23395 Muscle transfer, any type, shoulder or upper arm; single (Work RVU=18.29). The RUC noted that the surveyed code as compared to the MPC code has more total service time, 463 minutes and 423 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 19.42 RVUs for 2761X, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 19.42 Work RVUs for 2761X.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
28046	P84	090	12.20	The RUC reviewed the survey data for CPT code 28046 Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3 and compared it with its reference code 28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy (Work RVU=11.39). The RUC noted that the surveyed code has more total service time than the reference code, 334 minutes and 299 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 12.20 RVUs for 28046, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 12.20 Work RVUs for 28046.
2804X	P85	090	17.24	The RUC reviewed the survey data for CPT code 2804X Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; 3 cm or greater and compared it with its reference code 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) (Work RVU=23.04). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code has less total service time as compared to the reference code, 413 minutes and 469 minutes, respectively. In addition, the RUC compared the surveyed code to MPC code 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); (Work RVU=17.21). The RUC noted that the surveyed code as compared to the reference code has the same intra-service time, 120 minutes and similar total service times (413 minutes and 394 minutes). Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 17.24 RVUs for 2804X, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the radical codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the radical codes. The RUC recommends 17.24 Work RVUs for 2804X.

New Codes for Excision Recommendations

CPT Code #	*Tracking #*	*Global Period*	*RUC rec Work RVU*	*Rationale*
210X1	P1	090	2.91	The RUC reviewed the survey data for CPT code 210X1 Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm and compared it with its reference code 11642 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm (Work RVU=2.57). The RUC noted that although the surveyed code and reference code have very similar intensity and complexity measurements, the surveyed code as compared to the reference code had slightly more intra-service time (30 minutes and 25 minutes respectively and total service time (107 minutes and 68 minutes, respectively). The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 2.91 RVUs for 210X1, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 2.91 Work RVUs for 210X1.
210X2	P2	090	4.37	The RUC reviewed the survey data for CPT code 210X2 Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater and compared it with its reference code 11643 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm (Work RVU=3.37). The RUC noted that the surveyed code as compared to the reference code had more intra-service time (45 minutes and 30 minutes respectively and total service time (148 minutes and 93 minutes, respectively). Further, the RUC noted that the surveyed code required more technical skill and physical effort to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 4.37 RVUs for 210X2, which is a value between the 25th percentile and the surveyed median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 4.37 Work RVUs for 210X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
210X3	P3	090	5.34	The RUC reviewed the survey data for CPT code 210X3 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm and compared it with its reference code 38510 Biopsy or excision of lymph node(s); open, deep cervical node(s) (Work RVU=6.69). The RUC noted that although the surveyed code and the reference code have the same intra-service times (45 minutes), the reference code in comparison to the reference code requires, more mental effort and judgment and physical effort to perform than the surveyed code. Furthermore, the RUC compared the surveyed code to MPC code 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular (Work RVU=5.51). The RUC noted that the MPC code has more intra service time in comparison to the surveyed code, 60 minutes and 45 minutes respectively. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the MPC code and the reference code, the RUC recommends 5.34 RVUs for 210X3, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 5.34 Work RVUs for 210X3.
210X4	P4	090	7.00	The RUC reviewed the survey data for CPT code 210X4 Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater and compared it with its reference code 38510 Biopsy or excision of lymph node(s); open, deep cervical node(s) (Work RVU=6.69). The RUC noted that the surveyed code as compared to the reference code had more intra-service time (60 minutes and 45 minutes, respectively) and total service time (217 minutes and 152 minutes, respectively). Further, the RUC noted that the surveyed code required more technical skill and physical effort to perform than the reference code. The RUC also took into consideration that both of the reference codes have a 10-day global period compared with the surveyed code which has a 90-day global period. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 7.00 RVUs for 210X4, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. Furthermore, this value is also consistent with the recommendations for the subfascial family of codes. The RUC recommends 7.00 Work RVUs for 210X4.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
219X2	P15	090	9.71	The RUC reviewed the survey data for CPT code 219X2 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm and compared it with its reference code 15100 Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) (Work RVU=9.74). The RUC reviewed the survey data and agreed with the specialty society that a hospital visit and full day discharge visit were appropriate as the majority of survey respondents who stated that they typically perform this procedure in the hospital stated that the patient is kept overnight or admitted. The RUC noted that the surveyed code and the reference code have very similar total service times (276 minutes and 281 minutes, respectively) Further, the RUC noted that the surveyed code and the reference code have very similar intensity and complexity measurements. In addition, the RUC compared the surveyed code to another reference code 25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors (Work RVU=9.89). The RUC noted that the reference code has more intra service time in comparison to the surveyed code, 90 minutes and 60 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference codes, the RUC recommends 9.71 RVUs for 219X2, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 9.71 Work RVUs for 219X2.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
219X3	P16	090	11.00	The RUC reviewed the survey data for CPT code 219X3 Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5cm or greater and compared it with its reference code 38745 Axillary lymphadenectomy; complete (Work RVU=13.71). The RUC reviewed the survey data and agreed with the specialty society that a hospital visit and full day discharge visit were appropriate as the majority of survey respondents who stated that they typically perform this procedure in the hospital stated that the patient is kept overnight or admitted. Further, the RUC noted that although the surveyed code has the same intra-service time as the reference code, 90 minutes, respectively, the RUC agreed that this was a poor reference code. Therefore, the RUC agreed that a better reference code and keeping consistent with other recommendations from the subfascial family of codes would be 27822 Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip (Work RVU=11.03) as the surveyed code and 27822 reference code have the same intra-service time, 90 minutes and similar intensity of work. Due to these comparisons between the surveyed code and the 27822 reference code and to maintain relativity with the recommendations for the subfascial codes, the RUC recommends 11.00 RVUs, a value below the surveyed 25th percentile, for 219X3. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. Furthermore, this value is also consistent with the recommendations for the subfascial family of codes. The RUC recommends 11.00 Work RVUs for 219X3.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
229X0	P19	090	4.34	The RUC reviewed the survey data for CPT code 229X0 Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm and compared it with its reference code 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) (Work RVU=6.35). Although the surveyed code and the reference code have similar intensity and complexity measurements, the RUC noted that the surveyed code as compared to the reference code has less total service time (148 minutes and 178 minutes, respectively). In addition, the RUC compared the surveyed code to MPC code 11644 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm (Work RVU=4.29). The RUC noted that the surveyed code had significantly more total service time in comparison to the MPC code, 148 minutes and 108 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the reference code and the MPC code, the RUC recommends 4.34 RVUs for 229X0, which is a value between the 25 percentile and the survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 4.34 Work RVUs for 229X0.
229X1	P20	090	6.31	The RUC reviewed the survey data for CPT code 229X1 Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater and compared it with its reference code 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) (Work RVU=6.35). The RUC noted that the surveyed code and the reference code have very similar intra-service times (50 minutes and 45 minutes, respectively and total service times (179 minutes and 178 minutes, respectively) Further, the RUC noted that the surveyed code and the reference code have very similar intensity and complexity measurements. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 6.31 RVUs for 229X1, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 6.31 Work RVUs for 229X1.

CPT Code #	Tracking #	Global Period	RUC rec Work RVU	Rationale
229X3	P23	090	16.51	The RUC reviewed the survey data for CPT code 229X3 Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; less than 5 cm and compared it with its reference code 49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less (Work RVU=20.00). Although the surveyed code has greater intensity and complexity measurements as compared to the reference code, the RUC noted that the surveyed code as compared to the reference code has less total service time (396 minutes and 420 minutes, respectively). In addition, the RUC compared the surveyed code to MPC code 19318 Reduction mammaplasty (Work RVU=15.91). The RUC noted that the surveyed code has more total service time than the reference code, 396 minutes and 321 minutes, respectively. Therefore, the RUC agreed that because of these comparisons between the surveyed code, the MPC code and the reference code, the RUC recommends 16.51 RVUs for 229X3, which is a value below the surveyed 25th percentile. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. The RUC recommends 16.51 Work RVUs for 229X3.
229X4	P24	090	21.37	The RUC reviewed the survey data for CPT code 229X4 Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greater and compared it with its reference code 49203 Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less (Work RVU=20.00). The RUC noted that the surveyed code as compared to the reference code had more intra-service time (150 minutes and 120 minutes, respectively) and total service time (463 minutes and 420 minutes, respectively). Further, the RUC noted that the surveyed code required more mental effort and judgment, technical skill and physical effort to perform than the reference code. Therefore, the RUC agreed that because of these comparisons between the surveyed code and the reference code, the RUC recommends 21.37 RVUs for 229X4, which is a value between the 25th percentile and survey median. As described in the overall rationale, the RUC agreed that in order to preserve rank order with the recommendations for the subcutaneous codes, the recommendations for the new excision of soft tissue tumor codes should be reduced by 2.88% as well. The RUC recommended value for this procedure takes into account the 2.88% reduction applied to all of the new excision of soft tissue tumor codes. Furthermore, this value is also consistent with the recommendations for the subfascial family of codes. The RUC recommends 21.37 Work RVUs for 229X4.

AMA/Specialty Society RVS Update Committee **Tab 34**
Practice Expense Subcommittee Minutes
Thursday, January 29, 2009

Participating Members: Bill Moran, MD (Chair), Bibb Allen, MD, Katherine Bradley, PhD, RN, Joel Brill, MD, Manuel Cerqueira, MD, Thomas Cooper, MD, Thomas Felger, MD, David Hitzeman, DO , Peter A. Hollmann, MD, William J. Mangold, Jr., MD, Gregory Kwasny, MD, Tye Ouzounian, MD, and John A. Seibel, MD

Doctor Moran first welcomed the committee members and Sherry Smith presented an update on the AMA/Specialty Society Practice Information Survey.

Update on AMA/Specialty Society Practice Information Survey
Sherry Smith provided an update on the Physician Practice Information Survey. Ms. Smith informed the group that the survey has concluded and that staff was waiting for the results. Overall the survey was a success whereas approximately 100 responses per specialty. A full report of the results will be presented at the April RUC meeting. Ms. Smith's slideshow presentation is attached for your review.

The Practice Expense Subcommittee reviewed the following new, revised, and current issues and make the following recommendations to the RUC:
Relative Value Recommendations for CPT 2010:
The Practice Expense Subcommittee reviewed the following direct practice expense inputs recommendations:

Tab 4-8: Subcutaneous Soft Tissue Tumors, Excision of Subfacial Soft Tissue Tumors, Radical Resection of Soft Tissue Tumors, and Excision of New-Soft Tissue Tumors; The Subcommittee had an extensive discussion of the clinical labor time carefully and reduced clinical time that members believed was excessive for these types of procedures. In addition, the Subcommittee carefully scrutinized the supplies and equipment and made adjustments for the typical patient scenario. Pending staff research of the Review charts clinical staff time, this time was taken out and may be placed back in at the next meeting after review by the Subcommittee.

The Subcommittee makes the recommendation that the equipment item Camera, digital (6 megapixel) be deleted from all codes as equipment as it is much less expensive now, less than $500 (which excludes the item as an equipment item). CMS mentioned they may consider this recommendation in the proposed ruling and when specialties present comments they will consider adding this equipment item back into the codes.

Tab 9: Navigational Bronchoscopy --- Minor changes were made to the supplies presented by the specialty for this new add-on code
Tab 10: Laparoscopic Paraesophageal Hernia Repair – This issue is postponed pending further Panel consideration and possible reconsideration of the code descriptor(s)
Tab 11: Rectal Tumor Excision: The Subcommittee reviewed the inputs presented for the facility setting for these two new procedures and made minor adjustments to the clinical labor time and equipment time.
Tab 12: Temporary Prostatic Urethral Stent Insertion: The Subcommittee agreed with the inputs presented by the specialty society. There were no changes made.
Tab 13: Spinal Neurostimulator Electrode: This issue was postponed to the April 2009 RUC meeting.
Tab 14: Multi-Leaf Collimator IMRT Device Use: The Subcommittee agreed with the inputs as presented by the society and made one minor change to the time for equipment.
Tab 15: Coronary Computed Tomographic Angiography: The Subcommittee and specialty had a lengthy discussion in order to capture the typical clinical labor time for these services as well as the standard practice expense inputs. The Subcommittee made significant adjustments to the specialty society recommendations for clinical labor time, supplies and equipment, and agreed with the attached practice expense inputs.
Tab 16: Myocardial Perfusion Imaging: The Subcommittee agreed with the inputs presented by the specialty society. There were no changes made.
Tab 18: Nerve Conduction Tests: The Subcommittee discussed and reviewed the practice expense inputs and made changes to the clinical labor time and supplies in order to capture the typical patient scenario. This code is

typically billed with an evaluation and management code and therefore has no clinical labor time in the pre-service time period. The Subcommittee recommends that this code be placed on the New Technology list.

CMS Requests for Practice Expense Review

Tab 21: Interventional Radiology Procedures (36481): The specialty society had asked that code 36481 *Percutaneous portal vein catheterization by any method* be priced in the non-facility setting and was reviewed then postponed pending review of the additional review of the supervision and interpretation codes which are typically used with this code. The Subcommittee reviewed the specialty society's direct practice expense inputs recommendations and agreed that there was no overlap in the supervision and interpretation codes (75885 and 75887). The Subcommittee recommends code 36481 to be placed on CPT's Moderate Sedation listing (Appendix G), and recommend the inputs presented by the society and modified slightly by the Subcommittee.

Tab 25: Cryoablation of Prostate (55873): The specialty had asked that code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)* be priced in the non-facility setting and CMS asked then for the code to be reviewed for practice expense. At the October 2008 RUC meeting the issue was postponed pending a full RUC survey for physician time. The Subcommittee had a robust discussion of the practice expense inputs required for this service in the non-facility setting. The discussion centered around whether it was appropriate to provide these services, that require general anesthesia, in the non-facility setting. The Subcommittee made reductions in the clinical labor time and added a scapel to supplies to make its recommendation.

Tab 26: Hysteroscopy (58555, 58558, 58562, 58563): The specialty society requested additional supply packs be added to the hysteroscopy codes to reflect the typical patient service. The Subcommittee agreed with these additions.

Tab 29: End Stage Renal Disease (90951-90966): This issue were brought back to the Subcommittee for review of the RUC's practice expense recommendation from February 2008. CMS had requested clarification and justification of the reduction of practice expense direct inputs from the RUC's previous 2002 recommendation. This issue was postponed till the April RUC meeting.

Tab 31: Cardiology (93307, 93320, 93325): This committee had recommended direct inputs for code 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography* earlier, however did not recommend any changes to existing related codes. The Subcommittee reviewed the specialty recommendations and agreed with them making minor changes to the equipment time.

Tab 32: Measure Blood Oxygen Level (94760, 94761, 94762): These codes were identified by the RUC's 5 Year Review Identification Workgroup and were reviewed carefully and adjusted the clinical time, staff type, and medical supplies to reflect the typical patient service.

Tab 33: Moderate Sedation Practice Expense Inputs (22520, 22521): From a previous RUC recommendation, CMS had deleted the conscious sedation practice expense inputs that were not identified in CPT as having inherent moderate sedation as listed in its Appendix G. Specialties identified two services for which the deletion of these practice expense inputs was inappropriate. The Subcommittee discussed and agreed with the specialty and recommends the conscious sedation practice expense inputs be added back into codes 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic* and 22521 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar*.

Tab 34: Actigraphy (95803) CMS had asked the RUC to revisit its recommendation from April 2008 for code 95803 regarding several equipment questions. The specialty provided the information requested and the Subcommittee approved of the information submitted.

The Practice Expense Subcommittee would like the RUC to review the definition of Non-Facility as we are seeing services priced in the non-facility that require general anesthesia and being performed in physician offices and in independent diagnostic testing facilities.

AMA/Specialty Society RVS Update Committee
Research Subcommittee Report
Thursday, January 29, 2009

Members Present: Daniel Mark Siegel, MD (Chair), Emily Hill, PA-C, Brenda Lewis, DO, Eileen M. Moynihan, MD, Greg Przybylski, MD, Marc Raphaelson, MD, Samuel Smith, MD, Susan Spires, MD and James C. Waldorf, MD

I. Specialty Society Requests

American College of Obstetricians and Gynecologists (ACOG) and American Academy of Family Physicians (AAFP) – Review of a MMM Global Survey Instrument

The Research Subcommittee reviewed an initial survey instrument from ACOG/AAFP regarding their survey of the MMM codes. The Research Subcommittee gave extensive feedback to the societies on how to modify the survey instrument. ACOG/AAFP have submitted a revised survey instrument and cover letter for review.

The Research Subcommittee had lengthy discussions related to the inclusion of CMS non-covered services in their building block and incident to reporting. The Research Subcommittee agreed that CMS non-covered services should be maintained within the survey instrument to accurately account for the blocks of time physicians spend providing this service. Further, the Research Subcommittee agreed that there did not need to be a distinction made between physicians and Physicians' Assistants (PAs) as any portion of the service provided by a PA would be incident to the physician. **The Research Subcommittee recommends the survey instrument with the following modifications to the cover letter and survey instrument including:**

- **Cover Letter –**
  - **In the first paragraph, the term "payment" should be replaced with the term "valuation" and**
  - **The sentence, "These 2 areas will be the most critical to evaluate, since they most likely require the most work and a significant amount of risk." should be deleted.**
- **Survey Instrument –**
  - **Question 2 – the first sentence should read, "This question refers only to services provided <u>by the physician</u> prior to the hospital admission for the onset of labor." Further, weeks 43 and 44 should be removed from the grid**
  - **Background for Question 3 – the second sentence should read, "It will also include any time spent with the patient and her family during her labor, interpretation of the fetal monitor strip and placement of monitors if indicated." Further, the third sentence should be bolded and read, "This is not limited to face to face time with the patient, but may also include time on the floor or unit providing non-face to face patient care, not including office time" In addition, the second paragraph should be deleted.**
  - **Question 3 – the question should read, "Please identify how much time is spent providing care to the patient during each encounter of management of typical labor. Further, the critical care time column should be removed and the non-critical care column should read, Minutes.**
  - **Question 4 – the question should read, "Which of the reference services on the attached list is most similar to the delivery portion of the maternity**

service described on the cover of this questionnaire, with respect to the intra-service work.

- **Question 6b – the third sentence, "For critical care service exceeding 74 minutes, use 99291 and the appropriate number of 99292 services." should be deleted. Further, the hospital visits (critical care) section should be deleted and prolonged services (99356 and 99357) should be added**
- **Question 7 – the immediate post-service section should be deleted**

The Research Subcommittee determined that given the fact that the survey respondents will only use the reference service list when evaluating the delivery portion of the MMM service and not the post-operative visits, the most appropriate reference service list would only include: the CPT code number, descriptor and intra-service times listed in ascending order. The specialty society explained that when they construct their rationale, they would use a building block approach in which the surveyed delivery care times would be multiplied by the IWPUT associated with the reference code to impute a work RVU. **With the addition of five services primarily performed by family physicians and the above modifications, the Research Subcommittee recommends the reference service list.**

The specialty societies explained that they would be developing their vignettes and SORs which will be reviewed by the Research Subcommittee via conference call by February 25, 2009. The Research Subcommittee commented that the Summary of Recommendation Form (SOR) should have two tables, one table should display the survey data and the other table should display the societies' recommendations. The specialty societies plan to have several education sessions for potential survey respondents which will be staffed by AMA staff and one representative from the Research Subcommittee. The specialty societies plan to present their recommendations for the MMM codes at the October 2009 RUC Meeting.

II. Pre-Service Time Packages

North American Spine Society (NASS) – Review of Cover Letter and Survey Instrument for Pre-Service Time Standards

The Research Subcommittee was referred an issue by the Ad Hoc Pre-Time Workgroup. The Ad Hoc Pre-Time Workgroup met via conference call in January to discuss a proposal from the North American Spine Society to survey their members for pre-service time inputs. The Workgroup made some recommendations in how they should modify their survey instrument and cover letter before surveying their members so that these documents would serve as a model for other specialty societies. Further, the Ad Hoc Pre-Time Workgroup determined that the final instrument and cover letter should be reviewed by the Research Subcommittee. NASS submitted a revised survey instrument and cover letter for review by the Research Subcommittee. The Research Subcommittee modified the survey instrument so that Questions 1 and 3 be combined and that Questions 2 and 4 be combined so that the survey respondents will estimate minutes and how many times they have performed these surgical procedures in the past year at the same time, as specified below.

Positioning time **begins** when anesthesia induction is complete and the anesthesiologist gives permission to begin positioning the patient. It includes the time needed for positioning the patient, and any associated equipment (eg, fluoroscopy) prior to the start of prepping and draping. Positioning time **ends** when the surgical/procedure site is ready for prepping and draping.

Question # 1 Using the above definitions, how many minutes does it typically take you to perform for each of the following categories of spine surgical procedures and estimate the number of times you have personally performed these surgical procedures in the past year?

Question 1

Anterior Neck surgery (supine) (eg ACDF)	_____ minutes	_____ times
Posterior Neck surgery (prone) (eg laminectomy)	_____ minutes	_____ times
Posterior Thoracic/Lumbar (prone) (eg laminectomy)	_____ minutes	_____ times
Lateral Thoracic/Lumbar (lateral) (eg corpectomy)	_____ minutes	_____ times
Anterior Lumbar (supine) (eg ALIF)	_____ minutes	_____ times

Question #2 Using the above definitions, how many minutes does it typically take to position a patient for the following categories of spine injection procedures (awake or sedation not general anesthesia) and how many times you have personally performed these spinal injections in the past year?

Ouestion 2

Anterior Neck injection (supine) (eg discogram)	_____ minutes	_____ times
Posterior Neck injection (prone) (facet)	_____ minutes	_____ times
Posterior Thoracic/Lumbar (prone) (epidural)	_____ minutes	_____ times
Lateral Thoracic/Lumbar (lateral)(eg discogram)	_____ minutes	_____ times

With this modification to the survey instrument, the Research Subcommittee recommends the cover letter and survey instrument proposed by NASS.

AMA/Specialty Society RVS Update Committee **Tab 35**
Ad Hoc Pre-Service Time Workgroup
December 10, 2008

Members Present: Brenda Lewis, DO (Chair), Thomas Felger, MD, John Gage, MD, Emily Hill, PA-C, Gregory Kwasny, MD, and Samuel Smith, MD

I. Pre-Service Time Workgroup Background

The RUC developed pre-service time packages to be used in specialty society's recommendations to the RUC. These standards of time were reviewed by the original Pre-Service Time Workgroup and the Research Subcommittee and finally approved by the RUC. The Workgroup reviewed the original Pre-Service Time Workgroup's history by asking Barbara Levy, MD, former Chair of the Pre-Time Workgroup, various questions pertaining to why these pre-Service time packages were created, what assumptions were made when these packages were developed and the charges of the original Workgroup.

Doctor Lewis reviewed with the current Pre-Service Time Workgroup the charges as directed by the RUC. The Workgroup will be tasked to further refine the pre-service time packages. The Workgroup will also address the issue of retroactive application of pre-service time packages.

II. Pre-Service Time Workgroup Mission

Doctor Lewis reviewed the mission of the Ad Hoc Pre-Service Time Workgroup is to 1.) Further refine the existing pre-service time packages 2.) Identify all potential implications of the retroactive application of pre-service time packages to services within the RBRVS 3.) Consider whether it would be appropriate, given all potential implications, to retroactively apply these packages and 4.) If the Workgroup decides to retroactively apply these standards, what would be the appropriate process for the application of these standards

The Workgroup addressed the first part of the mission, further refinement of the existing pre-service time packages by reviewing the current pre-service time packages to determine if they accurately capture the activities and the time for these activities being performed in the pre-service time period. The Workgroup reviewed the letter submitted by the American College of Surgeons (ACS) which detailed some potential concerns with the pre-service time packages as they currently exist. One of the concerns raised by ACS was that the current pre-service time packages do not address a straightforward patient undergoing a straightforward procedure under general anesthetic. The current pre-service packages assume the same amount of time is required for supervision of moderate sedation as it does for the induction of a general anesthetic. The Workgroup agreed that the induction of a general anesthetic may require more time than does moderate sedation. The Workgroup based this opinion on induction times previously reviewed by the RUC for low base unit anesthesia codes which would support additional time for the induction of a general anesthetic.

The Workgroup discussed the pre-service time packages and agreed that first and foremost the pre-service time packages are guidelines and not absolutes. Specialty societies should use these packages as guidelines in developing their pre-service time recommendations to the RUC. More or less time may be justified in the pre-service time for a particular procedure providing the societies surveys support the addition or subtraction of time adjustments. The society should reflect the rationale for adjustments in their summary of recommendation submissions. This

mechanism has already been established in the current summary of recommendation form. Secondly, the Workgroup determined that the times approved by the RUC accurately describe the pre-service time activities as defined and does not recommend the addition of any new time packages. **To address the concern raised by the ACS, the Workgroup would like to add the following language to the note section of the pre-service time document:**

Additional time may be justified for a straightforward patient undergoing a straightforward procedure (Package 1B), if the procedure is performed under general anesthesia and the surveys support additional pre-service time.

A second issue raised by ACS was a concern that the pre-services packages that currently exist may not allow for specialties to support additional time when complex procedures require review of pathology reports and extensive imaging that is imperative to the operation. The Workgroup reiterated their opinion that the package times are guidelines and not absolutes but felt that additional time may be required in some procedures and could be used by a specialty to justify additional pre-service time if their surveys support additional time. **The Workgroup suggests addition of the following language which currently accompanies the pre-service time package instructions:**

"The Workgroup allows additional time if justified by the specialty society. The Workgroup believed additional increments of 15 minutes for TEE, Invasive monitoring , complex positioning, or extensive data review (reports or imaging studies as examples) may be appropriate for some procedures."

The Workgroup addressed the second part of the mission , the implications to the retroactive application of pre-service time packages to services within the Medicare Physician Payment Schedule. The RUC develops recommended work values based on surveys and relativity in relation to other codes in the fee schedule. If services are held to different pre-service standards and the packages are not retroactively applied it will be more difficult to keep relativity within the fee schedule. However, any retroactive application of these packages would be a massive workload for specialties and may not result in significant changes in overall RVU's since pre-service time is not the major determinate of overall RVU's for a service. Concerns were expressed that with a Fourth Five-Year Review approaching and an active rolling Five-Year Review the workload is unattainable by most specialties. Furthermore, the Workgroup is concerned that the current packages are still being refined and that any consideration to apply these packages to the entire fee schedule would be premature. Even if a subset of services were to be identified for review the range of values for any package has not been established and identifying potential outlying pre-service time codes would be difficult.

Therefore, the Workgroup determined that until there is more data from RUC recommendations utilizing the pre-service time packages, making RUC policy to address this issue would be premature. The Workgroup recommends that it will address this issue after the fourth Five-Year Review when a few years of data have been collected and can be statistically reviewed by the Workgroup. **However, in the interim, the Workgroup recommends that services that have utilized the pre-service time packages be flagged in the RUC database.**

AMA/Specialty Society RVS Update Committee **Tab 35**
Ad Hoc Pre-Service Time Workgroup
January 13, 2009

Members Present: Brenda Lewis, DO (Chair), Thomas Felger, MD, John Gage, MD, Emily Hill, PA-C, Gregory Kwasny, MD, Gregory Przybylski and Peter Smith, MD

I. North American Spine Society (NASS) Proposal

At the October 2008 RUC Meeting, the Research Subcommittee recommended that the Ad Hoc Pre-Service Time Workgroup be formed to further refine the pre-service time packages. The Workgroup was also to discuss new pre-service time standards proposed by specialty societies including the proposal from NASS.

The NASS proposal was to develop a survey instrument and collect data from a large number of spine surgeons and spine proceduralists on the time it takes to position patients for several categories of spinal procedures. NASS submitted a proposed survey instrument with this proposal. The Workgroup reviewed their request and survey instrument and discussed the potential outcomes including:

- streamlined review by RUC members of recommendations for spine procedures,
- new potential standards are not exhaustive or complete and specialty society will still need to justify additional time for positioning
- impact of these new potential standards on other specialties' recommendations, as unique positioning of patients is not exclusive to spine surgery
- increased accuracy of pre-time inputs
- potential for retrospective review with a rationale that the new standards were not used in previous recommendations

The Workgroup was receptive to additional information regarding pre-service times and agreed that this information could be very useful to the RUC in its review of specialty society's recommendations. However, in order to make their proposal accessible to all societies, the Workgroup agreed that some modifications needed to be made to the proposed survey instrument. The Workgroup recommended that the positions be limited to supine, lateral, posterior and prone. In addition, the Workgroup recommended that the delineation between stable and unstable spine be removed. **Once these changes are made, the Workgroup recommends that the modified survey instrument and cover letter be reviewed by the Research Subcommittee.**

After NASS has received final approval from the Research Subcommittee and has initiated their survey, their data will be reviewed by the Ad Hoc Pre-Time Workgroup to best determine how this data will be implemented into the RUC process.

AMA/Specialty Society RVS Update Committee **Tab 36**
Professional Liability Insurance Workgroup
January 30, 2009

Members Present: Doctors Peter Smith (Chair), Ronald Burd, Mary Foto, OTR, John Gage, David Hitzeman, Stephen Kamenetzky, Charles Koopmann, J. Leonard Lichtenfeld, Charles Mick, Najeeb Mohideen, Gregory Przybylski, Sandra Reed and Daniel Mark Siegel.

I. Meeting with CMS – PLI Methodology

On November 19, 2008 AMA Staff and the current and previous PLI Workgroup Chairmen, Doctors Peter Smith, David Hitzeman and Gregory Przybylski, met with CMS to discuss several issues surrounding the PLI methodology.

Doctor Peter Smith informed the Workgroup that he and the aforementioned individuals discussed the following issues with CMS:

- The PLI technical component methodology and the current lack of existence of separate liability insurance for technical staff;
- The collection of premium data, especially the concern to include all top specialties; (neurosurgery, obstetrics/gynecology and cardiothoracic surgery) as well as health care professionals data;
- Previously recommended Maxillofacial crosswalks;
- Utilizing the RUC low volume (< 100) dominant specialty recommendations; and
- Utilizing current premium data (PIAA submitted data).

The PLI Workgroup questioned whether those in attendance had a sense of progress regarding these issues. Doctor Smith confirmed that all believed that we made progress and clarified issues with all current CMS staff. CMS indicated that the issues may be discussed in the *Proposed Rule* this summer. CMS confirmed that their contractor is obtaining premiums for all specialties as designated by the states and Medicare's specialty identification classifications. This somewhat allayed the Workgroup's concerns regarding utilizing professional liability premiums for only a limited number of specialties.

The Workgroup expressed lingering concerns regarding the lack of use of current professional liability premiums that PIAA could supply. CMS indicated that they are contracting to obtain the most current data accessible. CMS has articulated a number of concerns related to utilizing the PIAA data: the ability to share these data and the future cost of obtaining such data. Additionally, CMS did review the PIAA data submitted for six previous pilot states and it was comparable to the data collected by their contractor. AMA staff indicated that the Physician Practice Information survey included PLI questions and these data will be available March 31, 2009. CMS may be able to utilize specific current data from this survey to confirm the data provided by the contractor.

II. Dominant Specialty for Low Volume Codes

At the November meeting with CMS, Doctor Smith indicated that the RUC recommended the use of the dominant specialty for low volume codes performed less than 100 times per year. CMS never implemented the dominant specialty in the PLI methodology. However, the agency has requested that the RUC resubmit these recommendations for consideration in proposed rulemaking.

In 2006, dominant specialties for 1,844 codes were submitted based on 2003 Medicare frequency data. In order to provide a current list AMA staff reran the query to identify codes with frequency less than 100, based on 2007 utilization data (1,839 codes).

All specialty societies were asked to review these low volume codes and provide a recommendation identifying the dominant specialty for those codes not previously on this list. This resulted in recommendations for specialty assignment to each of the codes for the purpose of calculating PLI. The recommended specialty designation was approved by the indicated specialty and, if necessary, by other affected specialties.

The document was circulated electronically prior to the workgroup meeting, and then systematically reviewed during the course of the meeting. All conflicts were resolved through discussion and the establishment of consensus involving specialties with demonstrated Medicare utilization and who had made recommendations for the dominant specialty. The PLI Workgroup reviewed all of these recommendations and by consensus recommends a dominant specialty assignment for each code.

The PLI Workgroup recommendations are attached (via e-mail attachment at the meeting).

Codes 99185 and 99186 were deleted from the screen as they have 0.00 work RVUs. However, the PLI workgroup did note that these codes incorrectly have PLI RVUs. The PLI Workgroup recommends that the PLI RVUs for codes 99185 and 99186 should be 0.00.

AMA
AMERICAN
MEDICAL
ASSOCIATION

February 13, 2009

Amy Bassano
Director, Division of Practitioner Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-01-14
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Bassano:

The American Medical Association/Specialty Society RVS Update Committee (RUC) convened January 29 – January 31, 2009. At this meeting, Doctor Peter Smith, Chair of the RUC's Professional Liability Insurance (PLI) Workgroup, briefed the Committee on the November 2008 meeting with CMS regarding the PLI methodology. The RUC is pleased that dialogue occurred and looks forward to working with the agency in 2009 the PLI relative values are revised for implementation on January 1, 2010.

The RUC reaffirmed the previous recommendation that CMS use the RUC recommended dominant specialty for low volume codes (defined as those performed less than 100 times per year), rather than rely on claims data. Utilization of claims data for low volume services results in anomalies within family of services. For example, in the section of CPT describing surgery of aneurysm, one code has claims from radiation oncologist and radiologists. The specialty performing this service is neurosurgery. This results in a PLI for 61708 (mis-coded by radiation oncology) of only 2.51, while the other PLI relative value within this family is 8.87 (CPT Code 61705). CMS did not implement the RUC dominant specialty recommendations for the PLI methodology as originally submitted in 2006. At this meeting the agency requested that the RUC resubmit these recommendations for consideration in proposed rulemaking in 2009.

The RUC reviewed 1,839 codes with utilization less than 100 Medicare claims per year based on 2007 utilization data. These codes were reviewed by the specialties, and recommendations made for appropriate dominant specialty assignment. Specialty society recommendations were reviewed at the January RUC PLI workgroup meeting, and final recommendations affirmed (attached). **The RUC recommends that CMS employ these dominant specialty assignments to determine PLI relative values for 2010.**

Additionally, the PLI workgroup noted that codes 99185 and 99186 have 0.00 work RVUs, but currently have PLI RVUs, 0.04 and 0.45 respectively. **The RUC recommends that the PLI RVUs for codes 99185 and 99186 be 0.00.** This is consistent with the RUC recommendation that services with no physician work (eg, TC component services) do not incur professional liability insurance costs.

We appreciate your review of this issue and look forward future improvements to the PLI methodology. Please contact Susan Clark via e-mail Susan.Clark@ama-assn.org or via phone (202) 789-7495 with any questions.

Sincerely,

William L. Rich, III, MD, FACS

cc: Rick Ensor
Whitney May
Peter Smith, MD
Don Thompson
RUC participants

RUC Recommended Dominant Specialty for PLI Methodology

CPT Code	Long Descriptor	Total 2007 Utilization (global +26+TC)	Dominant Specialty Medicare ID	Dominant Specialty based on 2007 Medicare Utilization (26 +global)	Recommended Specialty for PLI Methodology	Rec Medicare ID
00102	Anesthesia for procedures involving plastic repair of	76	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00172	Anesthesia for intraoral procedures, including biopsy;	63	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00174	Anesthesia for intraoral procedures, including biopsy;	67	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00326	Anesthesia for all procedures on the larynx and trachea	29	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00452	Anesthesia for procedures on clavicle and scapula;	79	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00454	Anesthesia for procedures on clavicle and scapula;	95	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00561	Anesthesia for procedures on heart, pericardial sac,	99	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00622	Anesthesia for procedures on thoracic spine and cord;	16	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00634	Anesthesia for procedures in lumbar region;	10	43	CRNA, ANESTHESIA	ANESTHESIOLOGY	05
00922	Anesthesia for procedures on male genitalia (including	87	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00924	Anesthesia for procedures on male genitalia (including	31	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00928	Anesthesia for procedures on male genitalia (including	63	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00934	Anesthesia for procedures on male genitalia (including	24	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
00936	Anesthesia for procedures on male genitalia (including	6	43	CRNA, ANESTHESIA	ANESTHESIOLOGY	05
00950	Anesthesia for vaginal procedures (including biopsy of	47	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01130	Anesthesia for body cast application or revision	36	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01140	Anesthesia for interpelviabdominal (hindquarter)	39	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01180	Anesthesia for obturator neurectomy; extrapelvic	12	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01190	Anesthesia for obturator neurectomy; intrapelvic	33	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01634	Anesthesia for open or surgical arthroscopic	40	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01636	Anesthesia for open or surgical arthroscopic	19	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01680	Anesthesia for shoulder cast application, removal or	28	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01682	Anesthesia for shoulder cast application, removal or	2	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01712	Anesthesia for procedures on nerves, muscles,	61	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01714	Anesthesia for procedures on nerves, muscles,	34	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01732	Anesthesia for diagnostic arthroscopic procedures of	68	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01852	Anesthesia for procedures on veins of forearm, wrist,	16	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01933	Anesthesia for therapeutic interventional radiological	46	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01962	Anesthesia for urgent hysterectomy following delivery	21	43	CRNA, ANESTHESIA	ANESTHESIOLOGY	05
01963	Anesthesia for cesarean hysterectomy without any	16	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
01969	Anesthesia for cesarean hysterectomy following	2	43	CRNA, ANESTHESIA	ANESTHESIOLOGY	05
01990	Physiological support for harvesting of organ(s) from	92	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
11922	Tattooing, intradermal introduction of insoluble opaque	96	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
11950	Subcutaneous injection of filling material (eg, collagen);	16	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
11951	Subcutaneous injection of filling material (eg, collagen);	35	48	PODIATRY	PLASTIC AND RECONSTUCTIVE SURGERY	24
11952	Subcutaneous injection of filling material (eg, collagen);	21	11	INTERNAL MEDICINE	PLASTIC AND RECONSTUCTIVE SURGERY	24
11954	Subcutaneous injection of filling material (eg, collagen);	33	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
11976	Removal, implantable contraceptive capsules	12	02	GENERAL SURGERY	OB-GYN	16
12017	Simple repair of superficial wounds of face, ears,	75	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93
12018	Simple repair of superficial wounds of face, ears,	22	97	PHYSICIANS ASSISTANT	EMERGENCY MEDICINE	93

RUC Recommended Dominant Specialty for PLI Methodology

CPT Code	Long Descriptor	Total 2007 Utilization (global +26+TC)	Dominant Specialty Medicare ID	Dominant Specialty based on 2007 Medicare Utilization (26 +global)	Recommended Specialty for PLI Methodology	Rec Medicare ID
12047	Repair, intermediate, wounds of neck, hands, feet	46	24	PLASTIC AND	GENERAL SURGERY	02
12056	Repair, intermediate, wounds of face, ears, eyelids,	66	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
12057	Repair, intermediate, wounds of face, ears, eyelids,	79	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15111	Epidermal autograft, trunk, arms, legs; each additional	97	02	GENERAL SURGERY	GENERAL SURGERY	02
15116	Epidermal autograft, face, scalp, eyelids, mouth, neck,	22	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15131	Dermal autograft, trunk, arms, legs; each additional	57	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15136	Dermal autograft, face, scalp, eyelids, mouth, neck,	9	02	GENERAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15150	Tissue cultured epidermal autograft, trunk, arms, legs;	42	02	GENERAL SURGERY	GENERAL SURGERY	02
15151	Tissue cultured epidermal autograft, trunk, arms, legs;	17	24	PLASTIC AND	GENERAL SURGERY	02
15155	Tissue cultured epidermal autograft, face, scalp,	13	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15156	Tissue cultured epidermal autograft, face, scalp,	3	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15157	Tissue cultured epidermal autograft, face, scalp,	5	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15336	Acellular dermal allograft, face, scalp, eyelids, mouth,	50	48	PODIATRY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15366	Tissue cultured allogeneic dermal substitute, face,	86	02	GENERAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15776	Punch graft for hair transplant; more than 15 punch	1	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15780	Dermabrasion; total face (eg, for acne scarring, fine	20	08	FAMILY PRACTICE	DERMATOLOGY	07
15782	Dermabrasion; regional, other than face	18	11	INTERNAL MEDICINE	DERMATOLOGY	07
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	17	07	DERMATOLOGY	DERMATOLOGY	07
15787	Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure)	33	08	FAMILY PRACTICE	DERMATOLOGY	07
15792	Chemical peel, nonfacial; epidermal	91	07	DERMATOLOGY	DERMATOLOGY	07
15793	Chemical peel, nonfacial; dermal	53	07	DERMATOLOGY	DERMATOLOGY	07
15819	Cervicoplasty	7	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15824	Rhytidectomy; forehead	4	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15828	Rhytidectomy; cheek, chin, and neck	23	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15829	Rhytidectomy; superficial musculoaponeurotic system	11	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15833	Excision, excessive skin and subcutaneous tissue	34	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15834	Excision, excessive skin and subcutaneous tissue	39	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15835	Excision, excessive skin and subcutaneous tissue	28	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15836	Excision, excessive skin and subcutaneous tissue	96	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15837	Excision, excessive skin and subcutaneous tissue	9	40	HAND SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15838	Excision, excessive skin and subcutaneous tissue	71	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15841	Graft for facial nerve paralysis; free muscle graft	27	14	NEUROSURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15842	Graft for facial nerve paralysis; free muscle flap by	4	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15860	Intravenous injection of agent (eg, fluorescein) to test	59	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15876	Suction assisted lipectomy; head and neck	11	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15877	Suction assisted lipectomy; trunk	30	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15878	Suction assisted lipectomy; upper extremity	5	33	THORACIC SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15879	Suction assisted lipectomy; lower extremity	3	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15922	Excision, coccygeal pressure ulcer, with	70	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24

RUC Recommended Dominant Specialty for PLI Methodology

CPT Code	Long Descriptor	Total 2007 Utilization (global +26+TC)	Dominant Specialty Medicare ID	Dominant Specialty based on 2007 Medicare Utilization (26 +global)	Recommended Specialty for PLI Methodology	Rec Medicare ID
15951	Excision, trochanteric pressure ulcer, with primary	72	02	GENERAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
15952	Excision, trochanteric pressure ulcer, with skin flap	58	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
15953	Excision, trochanteric pressure ulcer, with skin flap	50	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
17380	Electrolysis epilation, each 30 minutes	11	24	PLASTIC AND	DERMATOLOGY	07
19105	Ablation, cryosurgical, of fibroadenoma, including	9	02	GENERAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
19324	Mammaplasty, augmentation; without prosthetic	38	02	GENERAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
19355	Correction of inverted nipples	40	02	GENERAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
19368	Breast reconstruction with transverse rectus abdominis	16	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
19369	Breast reconstruction with transverse rectus abdominis	27	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
20101	Exploration of penetrating wound (separate procedure);	93	02	GENERAL SURGERY	GENERAL SURGERY	02
20150	Excision of epiphyseal bar, with or without autogenous	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
20662	Application of halo, including removal; pelvic	21	34	UROLOGY	ORTHOPEDIC SURGERY	20
20663	Application of halo, including removal; femoral	11	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
20664	Application of halo, including removal, cranial, 6 or	42	14	NEUROSURGERY	NEUROSURGERY	14
20802	Replantation, arm (includes surgical neck of humerus	1	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20
20805	Replantation, forearm (includes radius and ulna to	2	08	FAMILY PRACTICE	ORTHOPEDIC SURGERY	20
20808	Replantation, hand (includes hand through	2	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
20816	Replantation, digit, excluding thumb (includes	16	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
20822	Replantation, digit, excluding thumb (includes distal tip	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
20824	Replantation, thumb (includes carpometacarpal joint to	5	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
20827	Replantation, thumb (includes distal tip to MP joint),	9	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
20910	Cartilage graft; costochondral	69	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
20930	Allograft for spine surgery only; morselized (List	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
20936	Autograft for spine surgery only (includes harvesting	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
20956	Bone graft with microvascular anastomosis; iliac crest	24	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
20957	Bone graft with microvascular anastomosis; metatarsal	4	48	PODIATRY	ORTHOPEDIC SURGERY	20
20962	Bone graft with microvascular anastomosis; other than	29	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
20970	Free osteocutaneous flap with microvascular	19	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
20972	Free osteocutaneous flap with microvascular	1	48	PODIATRY	ORTHOPEDIC SURGERY	20
20973	Free osteocutaneous flap with microvascular	2	48	PODIATRY	ORTHOPEDIC SURGERY	20
21010	Arthrotomy, temporomandibular joint	11	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21047	Excision of benign tumor or cyst of mandible; requiring	65	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21049	Excision of benign tumor or cyst of maxilla; requiring	20	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21050	Condylectomy, temporomandibular joint (separate	22	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21060	Meniscectomy, partial or complete, temporomandibular	14	19	ORAL SURGERY (DENTISTS	MAXILLOFACIAL SURGERY	85
21070	Coronoidectomy (separate procedure)	73	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21077	Impression and custom preparation; orbital prosthesis	70	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
21082	Impression and custom preparation; palatal	94	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
21083	Impression and custom preparation; palatal lift	46	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
21084	Impression and custom preparation; speech aid	57	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19

CPT Code	Long Descriptor	Total 2007 Utilization (global +26+TC)	Dominant Specialty Medicare ID	Dominant Specialty based on 2007 Medicare Utilization (26 +global)	Recommended Specialty for PLI Methodology	Rec Medicare ID
21100	Application of halo type appliance for maxillofacial	5	14	NEUROSURGERY	ORAL SURGERY	19
21120	Genioplasty; augmentation (autograft, allograft,	10	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21121	Genioplasty; sliding osteotomy, single piece	6	85	MAXILLOFACIAL SURGERY	ORAL SURGERY	19
21122	Genioplasty; sliding osteotomies, 2 or more	1	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21125	Augmentation, mandibular body or angle; prosthetic	5	04	OTOLARYNGOLOGY	ORAL SURGERY	19
21127	Augmentation, mandibular body or angle; with bone	4	04	OTOLARYNGOLOGY	ORAL SURGERY	19
21137	Reduction forehead; contouring only	2	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21138	Reduction forehead; contouring and application of	12	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21141	Reconstruction midface, LeFort I; single piece,	25	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21142	Reconstruction midface, LeFort I; 2 pieces, segment	5	19	ORAL SURGERY (DENTISTS	MAXILLOFACIAL SURGERY	85
21143	Reconstruction midface, LeFort I; 3 or more pieces,	3	04	OTOLARYNGOLOGY	MAXILLOFACIAL SURGERY	85
21145	Reconstruction midface, LeFort I; single piece,	9	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21146	Reconstruction midface, LeFort I; 2 pieces, segment	4	24	PLASTIC AND	MAXILLOFACIAL SURGERY	85
21147	Reconstruction midface, LeFort I; 3 or more pieces,	1	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21150	Reconstruction midface, LeFort II; anterior intrusion	1	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21151	Reconstruction midface, LeFort II; any direction,	1	24	PLASTIC AND	OTOLARYNGOLOGY	04
21154	Reconstruction midface, LeFort III (extracranial), any	1	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21172	Reconstruction superior-lateral orbital rim and lower	37	18	OPHTHALMOLOGY	NEUROSURGERY	14
21175	Reconstruction, bifrontal, superior-lateral orbital rims	4	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21179	Reconstruction, entire or majority of forehead and/or	26	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21180	Reconstruction, entire or majority of forehead and/or	7	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21181	Reconstruction by contouring of benign tumor of cranial	13	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21182	Reconstruction of orbital walls, rims, forehead,	26	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21183	Reconstruction of orbital walls, rims, forehead,	2	18	OPHTHALMOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21184	Reconstruction of orbital walls, rims, forehead,	2	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21188	Reconstruction midface, osteotomies (other than	11	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21193	Reconstruction of mandibular rami, horizontal, vertical,	19	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
21194	Reconstruction of mandibular rami, horizontal, vertical,	27	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21195	Reconstruction of mandibular rami and/or body, sagittal	10	19	ORAL SURGERY (DENTISTS	OTOLARYNGOLOGY	04
21199	Osteotomy, mandible, segmental; with genioglossus	82	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21206	Osteotomy, maxilla, segmental (eg, Wassmund or	21	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21208	Osteoplasty, facial bones; augmentation (autograft,	77	24	PLASTIC AND	MAXILLOFACIAL SURGERY	85
21209	Osteoplasty, facial bones; reduction	25	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21230	Graft; rib cartilage, autogenous, to face, chin, nose or	62	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21242	Arthroplasty, temporomandibular joint, with allograft	21	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21243	Arthroplasty, temporomandibular joint, with prosthetic	48	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21245	Reconstruction of mandible or maxilla, subperiosteal	58	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21246	Reconstruction of mandible or maxilla, subperiosteal	13	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21247	Reconstruction of mandibular condyle with bone and	11	85	MAXILLOFACIAL SURGERY	ORAL SURGERY	19
21249	Reconstruction of mandible or maxilla, endosteal	61	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19

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21255	Reconstruction of zygomatic arch and glenoid fossa	8	24	PLASTIC AND	OTOLARYNGOLOGY	04
21256	Reconstruction of orbit with osteotomies (extracranial)	27	18	OPHTHALMOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21260	Periorbital osteotomies for orbital hypertelorism, with	1	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21267	Orbital repositioning, periorbital osteotomies, unilateral,	10	18	OPHTHALMOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21268	Orbital repositioning, periorbital osteotomies, unilateral,	1	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21270	Malar augmentation, prosthetic material	39	18	OPHTHALMOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21275	Secondary revision of orbitocraniofacial reconstruction	19	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21295	Reduction of masseter muscle and bone (eg, for	8	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21296	Reduction of masseter muscle and bone (eg, for	1	85	MAXILLOFACIAL SURGERY	OTOLARYNGOLOGY	04
21338	Open treatment of nasoethmoid fracture; without	37	24	PLASTIC AND	OTOLARYNGOLOGY	04
21339	Open treatment of nasoethmoid fracture; with external	11	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21340	Percutaneous treatment of nasoethmoid complex	6	24	PLASTIC AND	OTOLARYNGOLOGY	04
21343	Open treatment of depressed frontal sinus fracture	25	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21344	Open treatment of complicated (eg, comminuted or	53	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21345	Closed treatment of nasomaxillary complex fracture	11	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21346	Open treatment of nasomaxillary complex fracture	45	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21347	Open treatment of nasomaxillary complex fracture	62	24	PLASTIC AND	OTOLARYNGOLOGY	04
21348	Open treatment of nasomaxillary complex fracture	5	24	PLASTIC AND	OTOLARYNGOLOGY	04
21355	Percutaneous treatment of fracture of malar area,	20	85	MAXILLOFACIAL SURGERY	OTOLARYNGOLOGY	04
21366	Open treatment of complicated (eg, comminuted or	13	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21385	Open treatment of orbital floor blowout fracture;	58	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21386	Open treatment of orbital floor blowout fracture;	89	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21387	Open treatment of orbital floor blowout fracture;	44	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21395	Open treatment of orbital floor blowout fracture;	25	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21401	Closed treatment of fracture of orbit, except blowout;	8	85	MAXILLOFACIAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21406	Open treatment of fracture of orbit, except blowout;	78	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21408	Open treatment of fracture of orbit, except blowout;	17	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21421	Closed treatment of palatal or maxillary fracture (LeFort	37	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
21423	Open treatment of palatal or maxillary fracture (LeFort I	86	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21431	Closed treatment of craniofacial separation (LeFort III	2	24	PLASTIC AND	ORAL SURGERY	19
21432	Open treatment of craniofacial separation (LeFort III	10	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
21433	Open treatment of craniofacial separation (LeFort III	32	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21435	Open treatment of craniofacial separation (LeFort III	17	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21436	Open treatment of craniofacial separation (LeFort III	8	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
21440	Closed treatment of mandibular or maxillary alveolar	98	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21445	Open treatment of mandibular or maxillary alveolar	51	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
21451	Closed treatment of mandibular fracture; with	88	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
21452	Percutaneous treatment of mandibular fracture, with	19	85	MAXILLOFACIAL SURGERY	MAXILLOFACIAL SURGERY	85
21454	Open treatment of mandibular fracture with external	27	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
21465	Open treatment of mandibular condylar fracture	29	85	MAXILLOFACIAL SURGERY	ORAL SURGERY	19

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21490	Open treatment of temporomandibular dislocation	29	85	MAXILLOFACIAL SURGERY	ORAL SURGERY	19
21495	Open treatment of hyoid fracture	3	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
21497	Interdental wiring, for condition other than fracture	23	04	OTOLARYNGOLOGY	ORAL SURGERY	19
21502	Incision and drainage, deep abscess or hematoma, soft	39	02	GENERAL SURGERY	THORACIC SURGERY	02
21510	Incision, deep, with opening of bone cortex (eg, for	57	33	THORACIC SURGERY	THORACIC SURGERY	33
21610	Costotransversectomy (separate procedure)	41	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14
21615	Excision first and/or cervical rib;	85	77	VASCULAR SURGERY	THORACIC SURGERY	33
21632	Radical resection of sternum; with mediastinal	79	78	CARDIAC SURGERY	THORACIC SURGERY	33
21700	Division of scalenus anticus; without resection of	67	33	THORACIC SURGERY	VASCULAR SURGERY	77
21705	Division of scalenus anticus; with resection of cervical	13	77	VASCULAR SURGERY	VASCULAR SURGERY	77
21720	Division of sternocleidomastoid for torticollis, open	15	04	OTOLARYNGOLOGY	NEUROSURGERY	14
21725	Division of sternocleidomastoid for torticollis, open	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
21740	Reconstructive repair of pectus excavatum or	19	33	THORACIC SURGERY	THORACIC SURGERY	33
21805	Open treatment of rib fracture without fixation, each	24	33	THORACIC SURGERY	THORACIC SURGERY	33
21810	Treatment of rib fracture requiring external fixation (flail	22	33	THORACIC SURGERY	ORTHOPEDIC SURGERY	33
22100	Partial excision of posterior vertebral component (eg,	97	14	NEUROSURGERY	NEUROSURGERY	14
22101	Partial excision of posterior vertebral component (eg,	62	14	NEUROSURGERY	NEUROSURGERY	14
22110	Partial excision of vertebral body, for intrinsic bony	79	14	NEUROSURGERY	NEUROSURGERY	14
22112	Partial excision of vertebral body, for intrinsic bony	16	14	NEUROSURGERY	NEUROSURGERY	14
22114	Partial excision of vertebral body, for intrinsic bony	99	20	ORTHOPEDIC SURGERY	NEUROSURGERY	20
22116	Partial excision of vertebral body, for intrinsic bony	81	14	NEUROSURGERY	NEUROSURGERY	14
22222	Osteotomy of spine, including discectomy, anterior	24	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14
22319	Open treatment and/or reduction of odontoid fracture(s)	15	14	NEUROSURGERY	NEUROSURGERY	14
22527	Percutaneous intradiscal electrothermal annuloplasty,	52	72	PAIN MANAGEMENT	ANESTHESIOLOGY	05
22548	Arthrodesis, anterior transoral or extraoral technique,	69	14	NEUROSURGERY	NEUROSURGERY	14
22812	Arthrodesis, anterior, for spinal deformity, with or	19	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
22818	Kyphectomy, circumferential exposure of spine and	62	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
22819	Kyphectomy, circumferential exposure of spine and	11	14	NEUROSURGERY	ORTHOPEDIC SURGERY	20
22847	Anterior instrumentation; 8 or more vertebral segments	61	14	NEUROSURGERY	ORTHOPEDIC SURGERY	20
22856	Total disc arthroplasty (artificial disc), anterior	4	14	NEUROSURGERY	ORTHOPEDIC SURGERY	20
22857	Total disc arthroplasty (artificial disc), anterior	21	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
22865	Removal of total disc arthroplasty (artificial disc),	1	14	NEUROSURGERY	ORTHOPEDIC SURGERY	20
23100	Arthrotomy, glenohumeral joint, including biopsy	43	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23106	Arthrotomy; sternoclavicular joint, with synovectomy,	16	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23125	Claviculectomy; total	63	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23145	Excision or curettage of bone cyst or benign tumor of	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23146	Excision or curettage of bone cyst or benign tumor of	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23150	Excision or curettage of bone cyst or benign tumor of	87	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23155	Excision or curettage of bone cyst or benign tumor of	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23156	Excision or curettage of bone cyst or benign tumor of	36	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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23170	Sequestrectomy (eg, for osteomyelitis or bone	37	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23172	Sequestrectomy (eg, for osteomyelitis or bone	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23174	Sequestrectomy (eg, for osteomyelitis or bone	39	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23182	Partial excision (craterization, saucerization, or	66	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23190	Ostectomy of scapula, partial (eg, superior medial	35	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23195	Resection, humeral head	62	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23200	Radical resection for tumor; clavicle	49	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23210	Radical resection for tumor; scapula	42	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23220	Radical resection of bone tumor, proximal humerus;	37	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23221	Radical resection of bone tumor, proximal humerus;	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23222	Radical resection of bone tumor, proximal humerus;	53	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23397	Muscle transfer, any type, shoulder or upper arm;	52	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23400	Scapulopexy (eg, Sprengels deformity or for paralysis)	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23406	Tenotomy, shoulder area; multiple tendons through	74	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23460	Capsulorrhaphy, anterior, any type; with bone block	49	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23462	Capsulorrhaphy, anterior, any type; with coracoid	42	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or	83	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23480	Osteotomy, clavicle, with or without internal fixation;	95	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23490	Prophylactic treatment (nailing, pinning, plating or	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23491	Prophylactic treatment (nailing, pinning, plating or	67	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23520	Closed treatment of sternoclavicular dislocation;	68	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23525	Closed treatment of sternoclavicular dislocation; with	26	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23530	Open treatment of sternoclavicular dislocation, acute or	14	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23532	Open treatment of sternoclavicular dislocation, acute or	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23545	Closed treatment of acromioclavicular dislocation; with	80	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93
23575	Closed treatment of scapular fracture; with	58	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23800	Arthrodesis, glenohumeral joint;	29	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23802	Arthrodesis, glenohumeral joint; with autogenous graft	8	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23900	Interthoracoscapular amputation (forequarter)	24	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23920	Disarticulation of shoulder;	39	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
23921	Disarticulation of shoulder; secondary closure or scar	2	08	FAMILY PRACTICE	ORTHOPEDIC SURGERY	20
24100	Arthrotomy, elbow; with synovial biopsy only	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24110	Excision or curettage of bone cyst or benign tumor,	96	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24115	Excision or curettage of bone cyst or benign tumor,	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24116	Excision or curettage of bone cyst or benign tumor,	18	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24125	Excision or curettage of bone cyst or benign tumor of	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24126	Excision or curettage of bone cyst or benign tumor of	9	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24134	Sequestrectomy (eg, for osteomyelitis or bone	34	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24136	Sequestrectomy (eg, for osteomyelitis or bone	2	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20
24138	Sequestrectomy (eg, for osteomyelitis or bone	52	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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24145	Partial excision (craterization, saucerization, or	44	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24150	Radical resection for tumor, shaft or distal humerus;	56	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24151	Radical resection for tumor, shaft or distal humerus;	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24152	Radical resection for tumor, radial head or neck;	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24153	Radical resection for tumor, radial head or neck; with	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24155	Resection of elbow joint (arthrectomy)	14	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24164	Implant removal; radial head	61	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24301	Muscle or tendon transfer, any type, upper arm or	70	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24320	Tenoplasty, with muscle transfer, with or without free	22	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24330	Flexor-plasty, elbow (eg, Steindler type advancement);	55	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24331	Flexor-plasty, elbow (eg, Steindler type advancement);	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24332	Tenolysis, triceps	37	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24344	Reconstruction lateral collateral ligament, elbow, with	52	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24345	Repair medial collateral ligament, elbow, with local	88	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24346	Reconstruction medial collateral ligament, elbow, with	15	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24360	Arthroplasty, elbow; with membrane (eg, fascial)	43	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24361	Arthroplasty, elbow; with distal humeral prosthetic	62	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24362	Arthroplasty, elbow; with implant and fascia lata	8	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24365	Arthroplasty, radial head;	65	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24410	Multiple osteotomies with realignment on	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24420	Osteoplasty, humerus (eg, shortening or lengthening)	28	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24565	Closed treatment of humeral epicondylar fracture,	33	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24566	Percutaneous skeletal fixation of humeral epicondylar	17	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24577	Closed treatment of humeral condylar fracture, medial	48	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24582	Percutaneous skeletal fixation of humeral condylar	32	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation	67	93	EMERGENCY MEDICINE	PEDIATRIC MEDICINE	37
24800	Arthrodesis, elbow joint; local	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24802	Arthrodesis, elbow joint; with autogenous graft	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24920	Amputation, arm through humerus; open, circular	29	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24925	Amputation, arm through humerus; secondary closure	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24930	Amputation, arm through humerus; re-amputation	23	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
24935	Stump elongation, upper extremity	1	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20
25023	Decompression fasciotomy, forearm and/or wrist, flexor	90	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25025	Decompression fasciotomy, forearm and/or wrist, flexor	64	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25031	Incision and drainage, forearm and/or wrist; bursa	92	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25085	Capsulotomy, wrist (eg, contracture)	89	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25100	Arthrotomy, wrist joint; with biopsy	59	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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25125	Excision or curettage of bone cyst or benign tumor of	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25126	Excision or curettage of bone cyst or benign tumor of	19	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25135	Excision or curettage of bone cyst or benign tumor of	19	40	HAND SURGERY	ORTHOPEDIC SURGERY	20
25136	Excision or curettage of bone cyst or benign tumor of	10	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25145	Sequestrectomy (eg, for osteomyelitis or bone	42	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25170	Radical resection for tumor, radius or ulna	20	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25250	Removal of wrist prosthesis; (separate procedure)	46	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25251	Removal of wrist prosthesis; complicated, including	28	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25263	Repair, tendon or muscle, flexor, forearm and/or wrist;	83	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25265	Repair, tendon or muscle, flexor, forearm and/or wrist;	43	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25275	Repair, tendon sheath, extensor, forearm and/or wrist,	65	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25300	Tenodesis at wrist; flexors of fingers	79	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25315	Flexor origin slide (eg, for cerebral palsy, Volkmann	68	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25316	Flexor origin slide (eg, for cerebral palsy, Volkmann	17	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25335	Centralization of wrist on ulna (eg, radial club hand)	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25355	Osteotomy, radius; middle or proximal third	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25365	Osteotomy; radius AND ulna	11	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25370	Multiple osteotomies, with realignment on	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25375	Multiple osteotomies, with realignment on	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25391	Osteoplasty, radius OR ulna; lengthening with autograft	35	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25392	Osteoplasty, radius AND ulna; shortening (excluding	2	40	HAND SURGERY	ORTHOPEDIC SURGERY	20
25393	Osteoplasty, radius AND ulna; lengthening with	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25394	Osteoplasty, carpal bone, shortening	19	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25415	Repair of nonunion or malunion, radius AND ulna;	50	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25420	Repair of nonunion or malunion, radius AND ulna; with	35	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25425	Repair of defect with autograft; radius OR ulna	24	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25430	Insertion of vascular pedicle into carpal bone (eg, Hori	8	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25431	Repair of nonunion of carpal bone (excluding carpal	11	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25441	Arthroplasty with prosthetic replacement; distal radius	17	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25443	Arthroplasty with prosthetic replacement; scaphoid	15	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25444	Arthroplasty with prosthetic replacement; lunate	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25449	Revision of arthroplasty, including removal of implant,	80	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25490	Prophylactic treatment (nailing, pinning, plating or	26	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25491	Prophylactic treatment (nailing, pinning, plating or	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25492	Prophylactic treatment (nailing, pinning, plating or	3	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25520	Closed treatment of radial shaft fracture and closed	57	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25624	Closed treatment of carpal scaphoid (navicular)	83	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25635	Closed treatment of carpal bone fracture (excluding	67	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25645	Open treatment of carpal bone fracture (other than	43	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25670	Open treatment of radiocarpal or intercarpal	99	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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25671	Percutaneous skeletal fixation of distal radioulnar	99	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25685	Open treatment of trans-scaphoperilunar type of	48	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25690	Closed treatment of lunate dislocation, with	36	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25695	Open treatment of lunate dislocation	45	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25805	Arthrodesis, wrist; with sliding graft	85	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25830	Arthrodesis, distal radioulnar joint with segmental	79	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25905	Amputation, forearm, through radius and ulna; open,	20	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25907	Amputation, forearm, through radius and ulna;	13	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
25909	Amputation, forearm, through radius and ulna; re-	23	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25915	Krukenberg procedure	1	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25920	Disarticulation through wrist;	74	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25922	Disarticulation through wrist; secondary closure or scar	8	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
25924	Disarticulation through wrist; re-amputation	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25927	Transmetacarpal amputation;	81	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25929	Transmetacarpal amputation; secondary closure or	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
25931	Transmetacarpal amputation; re-amputation	15	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26035	Decompression fingers and/or hand, injection injury	69	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26100	Arthrotomy with biopsy; carpometacarpal joint, each	45	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26105	Arthrotomy with biopsy; metacarpophalangeal joint,	80	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26130	Synovectomy, carpometacarpal joint	95	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26185	Sesamoidectomy, thumb or finger (separate procedure)	48	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26205	Excision or curettage of bone cyst or benign tumor of	17	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26215	Excision or curettage of bone cyst or benign tumor of	46	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26250	Radical resection, metacarpal (eg, tumor);	19	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26255	Radical resection, metacarpal (eg, tumor); with	2	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20
26260	Radical resection, proximal or middle phalanx of finger	29	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26261	Radical resection, proximal or middle phalanx of finger	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26262	Radical resection, distal phalanx of finger (eg, tumor)	38	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
26352	Repair or advancement, flexor tendon, not in zone 2	44	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26357	Repair or advancement, flexor tendon, in zone 2 digital	73	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26358	Repair or advancement, flexor tendon, in zone 2 digital	37	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26372	Repair or advancement of profundus tendon, with intact	28	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26373	Repair or advancement of profundus tendon, with intact	19	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26390	Excision flexor tendon, with implantation of synthetic	43	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26392	Removal of synthetic rod and insertion of flexor tendon	31	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26415	Excision of extensor tendon, with implantation of	37	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26416	Removal of synthetic rod and insertion of extensor	5	76	PERIPERAL VASCULAR	ORTHOPEDIC SURGERY	20
26420	Repair, extensor tendon, finger, primary or secondary;	82	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26428	Repair of extensor tendon, central slip, secondary (eg,	17	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26434	Repair of extensor tendon, distal insertion, primary or	8	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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26474	Tenodesis; of distal joint, each joint	52	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26476	Lengthening of tendon, extensor, hand or finger, each	60	40	HAND SURGERY	ORTHOPEDIC SURGERY	20
26479	Shortening of tendon, flexor, hand or finger, each	19	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26489	Transfer or transplant of tendon, palmar; with free	46	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26492	Opponensplasty; tendon transfer with graft (includes	36	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26494	Opponensplasty; hypothenar muscle transfer	10	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26496	Opponensplasty; other methods	89	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26497	Transfer of tendon to restore intrinsic function; ring and	55	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26498	Transfer of tendon to restore intrinsic function; all four	45	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26499	Correction claw finger, other methods	9	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26502	Reconstruction of tendon pulley, each tendon; with	61	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26517	Capsulodesis, metacarpophalangeal joint; 2 digits	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26518	Capsulodesis, metacarpophalangeal joint; 3 or 4 digits	11	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26545	Reconstruction, collateral ligament, interphalangeal	96	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26550	Pollicization of a digit	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26555	Transfer, finger to another position without	5	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
26556	Transfer, free toe joint, with microvascular anastomosis	3	93	EMERGENCY MEDICINE	ORTHOPEDIC SURGERY	24
26560	Repair of syndactyly (web finger) each web space; with	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26561	Repair of syndactyly (web finger) each web space; with	21	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
26562	Repair of syndactyly (web finger) each web space;	2	97	PHYSICIANS ASSISTANT	ORTHOPEDIC SURGERY	20
26565	Osteotomy; metacarpal, each	99	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26568	Osteoplasty, lengthening, metacarpal or phalanx	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26580	Repair cleft hand	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26587	Reconstruction of polydactylous digit, soft tissue and	7	48	PODIATRY	ORTHOPEDIC SURGERY	20
26590	Repair macrodactylia, each digit	4	77	VASCULAR SURGERY	ORTHOPEDIC SURGERY	20
26596	Excision of constricting ring of finger, with multiple Z-	41	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26645	Closed treatment of carpometacarpal fracture	95	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26665	Open treatment of carpometacarpal fracture	83	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26675	Closed treatment of carpometacarpal dislocation, other	28	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26685	Open treatment of carpometacarpal dislocation, other	68	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26686	Open treatment of carpometacarpal dislocation, other	31	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26820	Fusion in opposition, thumb, with autogenous graft	24	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26842	Arthrodesis, carpometacarpal joint, thumb, with or	89	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26843	Arthrodesis, carpometacarpal joint, digit, other than	36	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26844	Arthrodesis, carpometacarpal joint, digit, other than	36	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
26863	Arthrodesis, interphalangeal joint, with or without	68	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27003	Tenotomy, adductor, subcutaneous, open, with	31	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27035	Denervation, hip joint, intrapelvic or extrapelvic intra-	31	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
27050	Arthrotomy, with biopsy; sacroiliac joint	14	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27052	Arthrotomy, with biopsy; hip joint	78	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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27060	Excision; ischial bursa	51	02	GENERAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
27067	Excision of bone cyst or benign tumor; with autograft	10	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27075	Radical resection of tumor or infection; wing of ilium,	99	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27076	Radical resection of tumor or infection; ilium, including	94	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27077	Radical resection of tumor or infection; innominate	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27078	Radical resection of tumor or infection; ischial	46	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27079	Radical resection of tumor or infection; ischial	20	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20
27097	Release or recession, hamstring, proximal	47	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27098	Transfer, adductor to ischium	22	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27100	Transfer external oblique muscle to greater trochanter	42	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27105	Transfer paraspinal muscle to hip (includes fascial or	8	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27110	Transfer iliopsoas; to greater trochanter of femur	30	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27111	Transfer iliopsoas; to femoral neck	5	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27120	Acetabuloplasty; (eg, Whitman, Colonna, Haygroves,	80	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27146	Osteotomy, iliac, acetabular or innominate bone;	41	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27147	Osteotomy, iliac, acetabular or innominate bone; with	8	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27151	Osteotomy, iliac, acetabular or innominate bone; with	24	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27156	Osteotomy, iliac, acetabular or innominate bone; with	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27158	Osteotomy, pelvis, bilateral (eg, congenital	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27175	Treatment of slipped femoral epiphysis; by traction,	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27176	Treatment of slipped femoral epiphysis; by single or	40	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27177	Open treatment of slipped femoral epiphysis; single or	9	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27178	Open treatment of slipped femoral epiphysis; closed	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27179	Open treatment of slipped femoral epiphysis;	29	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27181	Open treatment of slipped femoral epiphysis;	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27202	Open treatment of coccygeal fracture	18	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27215	Open treatment of iliac spine(s), tuberosity avulsion, or	78	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27258	Open treatment of spontaneous hip dislocation	97	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27259	Open treatment of spontaneous hip dislocation	5	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27282	Arthrodesis, symphysis pubis (including obtaining graft)	6	16	OBSTETRICS/GYNECOLOGY	ORTHOPEDIC SURGERY	20
27284	Arthrodesis, hip joint (including obtaining graft);	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27286	Arthrodesis, hip joint (including obtaining graft); with	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27290	Interpelviabdominal amputation (hindquarter	32	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27306	Tenotomy, percutaneous, adductor or hamstring; single	84	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27307	Tenotomy, percutaneous, adductor or hamstring;	67	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27325	Neurectomy, hamstring muscle	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27326	Neurectomy, popliteal (gastrocnemius)	18	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27333	Arthrotomy, with excision of semilunar cartilage	42	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27356	Excision or curettage of bone cyst or benign tumor of	98	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27358	Excision or curettage of bone cyst or benign tumor of	26	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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27390	Tenotomy, open, hamstring, knee to hip; single tendon	47	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27391	Tenotomy, open, hamstring, knee to hip; multiple	54	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27392	Tenotomy, open, hamstring, knee to hip; multiple	28	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27393	Lengthening of hamstring tendon; single tendon	67	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27395	Lengthening of hamstring tendon; multiple tendons,	28	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27396	Transplant or transfer (with muscle redirection or	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27397	Transplant or transfer (with muscle redirection or	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27400	Transfer, tendon or muscle, hamstrings to femur (eg,	33	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27407	Repair, primary, torn ligament and/or capsule, knee;	29	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27409	Repair, primary, torn ligament and/or capsule, knee;	17	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27412	Autologous chondrocyte implantation, knee	47	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27415	Osteochondral allograft, knee, open	39	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27424	Reconstruction of dislocating patella; with patellectomy	74	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27428	Ligamentous reconstruction (augmentation), knee; intra-	83	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27429	Ligamentous reconstruction (augmentation), knee; intra-	55	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27440	Arthroplasty, knee, tibial plateau;	27	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27441	Arthroplasty, knee, tibial plateau; with debridement and	35	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27442	Arthroplasty, femoral condyles or tibial plateau(s),	92	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27443	Arthroplasty, femoral condyles or tibial plateau(s),	57	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27454	Osteotomy, multiple, with realignment on	23	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27457	Osteotomy, proximal tibia, including fibular excision or	86	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27465	Osteoplasty, femur; shortening (excluding 64876)	33	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27468	Osteoplasty, femur; combined, lengthening and	0	97	PHYSICIANS ASSISTANT	ORTHOPEDIC SURGERY	20
27475	Arrest, epiphyseal, any method (eg, epiphysiodesis);	7	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27477	Arrest, epiphyseal, any method (eg, epiphysiodesis);	24	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27479	Arrest, epiphyseal, any method (eg, epiphysiodesis);	4	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or	16	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27496	Decompression fasciotomy, thigh and/or knee, one	49	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27497	Decompression fasciotomy, thigh and/or knee, one	16	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27498	Decompression fasciotomy, thigh and/or knee, multiple	46	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27499	Decompression fasciotomy, thigh and/or knee, multiple	17	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27516	Closed treatment of distal femoral epiphyseal	33	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27517	Closed treatment of distal femoral epiphyseal	10	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27519	Open treatment of distal femoral epiphyseal separation,	25	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27556	Open treatment of knee dislocation, includes internal	67	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27557	Open treatment of knee dislocation, includes internal	15	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27558	Open treatment of knee dislocation, includes internal	14	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27562	Closed treatment of patellar dislocation; requiring	41	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27566	Open treatment of patellar dislocation, with or without	79	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27637	Excision or curettage of bone cyst or benign tumor,	38	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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27638	Excision or curettage of bone cyst or benign tumor,	95	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27645	Radical resection of tumor, bone; tibia	65	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27646	Radical resection of tumor, bone; fibula	42	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27656	Repair, fascial defect of leg	46	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27676	Repair, dislocating peroneal tendons; with fibular	86	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle;	46	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27703	Arthroplasty, ankle; revision, total ankle	96	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27712	Osteotomy; multiple, with realignment on	29	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27715	Osteoplasty, tibia and fibula, lengthening or shortening	69	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27722	Repair of nonunion or malunion, tibia; with sliding graft	25	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27725	Repair of nonunion or malunion, tibia; by synostosis,	49	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27730	Arrest, epiphyseal (epiphysiodesis), open; distal tibia	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27732	Arrest, epiphyseal (epiphysiodesis), open; distal fibula	5	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27830	Closed treatment of proximal tibiofibular joint	26	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27831	Closed treatment of proximal tibiofibular joint	5	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27832	Open treatment of proximal tibiofibular joint dislocation,	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
27893	Decompression fasciotomy, leg; posterior	37	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20
28050	Arthrotomy with biopsy; intertarsal or tarsometatarsal	86	48	PODIATRY	PODIATRY	48
28102	Excision or curettage of bone cyst or benign tumor,	17	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28103	Excision or curettage of bone cyst or benign tumor,	44	48	PODIATRY	PODIATRY	48
28106	Excision or curettage of bone cyst or benign tumor,	59	48	PODIATRY	PODIATRY	48
28107	Excision or curettage of bone cyst or benign tumor,	52	48	PODIATRY	PODIATRY	48
28130	Talectomy (astragalectomy)	77	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28171	Radical resection of tumor, bone; tarsal (except talus or	32	48	PODIATRY	ORTHOPEDIC SURGERY	20
28226	Tenolysis, extensor, foot; multiple tendons	71	48	PODIATRY	PODIATRY	48
28262	Capsulotomy, midfoot; extensive, including posterior	98	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28264	Capsulotomy, midtarsal (eg, Heyman type procedure)	77	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28302	Osteotomy; talus	31	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28307	Osteotomy, with or without lengthening, shortening or	76	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28340	Reconstruction, toe, macrodactyly; soft tissue resection	16	48	PODIATRY	PODIATRY	48
28341	Reconstruction, toe, macrodactyly; requiring bone	30	48	PODIATRY	PODIATRY	48
28344	Reconstruction, toe(s); polydactyly	5	20	ORTHOPEDIC SURGERY	PODIATRY	48
28345	Reconstruction, toe(s); syndactyly, with or without skin	88	48	PODIATRY	PODIATRY	48
28360	Reconstruction, cleft foot	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28420	Open treatment of calcaneal fracture, includes internal	42	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28435	Closed treatment of talus fracture; with manipulation	56	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28436	Percutaneous skeletal fixation of talus fracture, with	23	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28456	Percutaneous skeletal fixation of tarsal bone fracture	42	48	PODIATRY	ORTHOPEDIC SURGERY	20
28531	Open treatment of sesamoid fracture, with or without	20	48	PODIATRY	PODIATRY	48
28545	Closed treatment of tarsal bone dislocation, other than	25	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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28546	Percutaneous skeletal fixation of tarsal bone	11	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28575	Closed treatment of talotarsal joint dislocation;	40	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28576	Percutaneous skeletal fixation of talotarsal joint	25	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
28605	Closed treatment of tarsometatarsal joint dislocation;	54	48	PODIATRY	ORTHOPEDIC SURGERY	20
28636	Percutaneous skeletal fixation of metatarsophalangeal	66	48	PODIATRY	ORTHOPEDIC SURGERY	20
29000	Application of halo type body cast (see 20661-20663	18	14	NEUROSURGERY	NEUROSURGERY	14
29010	Application of Risser jacket, localizer, body; only	6	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29015	Application of Risser jacket, localizer, body; including	10	08	FAMILY PRACTICE	ORTHOPEDIC SURGERY	20
29020	Application of turnbuckle jacket, body; only	1	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20
29025	Application of turnbuckle jacket, body; including head	2	18	OPHTHALMOLOGY	ORTHOPEDIC SURGERY	20
29035	Application of body cast, shoulder to hips;	10	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29040	Application of body cast, shoulder to hips; including	1	93	EMERGENCY MEDICINE	ORTHOPEDIC SURGERY	20
29044	Application of body cast, shoulder to hips; including	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29046	Application of body cast, shoulder to hips; including	5	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29049	Application, cast; figure-of-eight	11	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29055	Application, cast; shoulder spica	49	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29058	Application, cast; plaster Velpeau	61	93	EMERGENCY MEDICINE	ORTHOPEDIC SURGERY	20
29305	Application of hip spica cast; one leg	29	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29325	Application of hip spica cast; one and one-half spica or	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29358	Application of long leg cast brace	65	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29710	Removal or bivalving; shoulder or hip spica, Minerva,	27	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29715	Removal or bivalving; turnbuckle jacket	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29750	Wedging of clubfoot cast	2	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29800	Arthroscopy, temporomandibular joint, diagnostic, with	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29830	Arthroscopy, elbow, diagnostic, with or without synovial	21	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29835	Arthroscopy, elbow, surgical; synovectomy, partial	50	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29836	Arthroscopy, elbow, surgical; synovectomy, complete	76	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29840	Arthroscopy, wrist, diagnostic, with or without synovial	76	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29843	Arthroscopy, wrist, surgical; for infection, lavage and	36	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29847	Arthroscopy, wrist, surgical; internal fixation for fracture	45	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29850	Arthroscopically aided treatment of intercondylar	13	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29851	Arthroscopically aided treatment of intercondylar	19	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29856	Arthroscopically aided treatment of tibial fracture,	15	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29860	Arthroscopy, hip, diagnostic with or without synovial	37	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29861	Arthroscopy, hip, surgical; with removal of loose body	36	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29866	Arthroscopy, knee, surgical; osteochondral autograft(s)	43	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29867	Arthroscopy, knee, surgical; osteochondral allograft	34	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29868	Arthroscopy, knee, surgical; meniscal transplantation	10	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29885	Arthroscopy, knee, surgical; drilling for osteochondritis	51	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29889	Arthroscopically aided posterior cruciate ligament	77	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20

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29892	Arthroscopically aided repair of large osteochondritis	50	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
29900	Arthroscopy, metacarpophalangeal joint, diagnostic,	3	02	GENERAL SURGERY	ORTHOPEDIC SURGERY	20
29901	Arthroscopy, metacarpophalangeal joint, surgical; with	25	66	RHEUMATOLOGY	ORTHOPEDIC SURGERY	20
29902	Arthroscopy, metacarpophalangeal joint, surgical; with	3	66	RHEUMATOLOGY	ORTHOPEDIC SURGERY	20
30125	Excision dermoid cyst, nose; complex, under bone or	38	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
30160	Rhinectomy; total	68	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
30320	Removal foreign body, intranasal; by lateral rhinotomy	5	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
30400	Rhinoplasty, primary; lateral and alar cartilages and/or	90	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
30410	Rhinoplasty, primary; complete, external parts including	67	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
30430	Rhinoplasty, secondary; minor revision (small amount	64	24	PLASTIC AND	OTOLARYNGOLOGY	04
30435	Rhinoplasty, secondary; intermediate revision (bony	31	24	PLASTIC AND	OTOLARYNGOLOGY	04
30450	Rhinoplasty, secondary; major revision (nasal tip work	51	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
30460	Rhinoplasty for nasal deformity secondary to congenital	13	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
30462	Rhinoplasty for nasal deformity secondary to congenital	12	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
30540	Repair choanal atresia; intranasal	11	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
30545	Repair choanal atresia; transpalatine	2	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
30600	Repair fistula; oronasal	76	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
31040	Pterygomaxillary fossa surgery, any approach	84	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31051	Sinusotomy, sphenoid, with or without biopsy; with	97	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31075	Sinusotomy frontal; transorbital, unilateral (for	90	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31080	Sinusotomy frontal; obliterative without osteoplastic	21	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31081	Sinusotomy frontal; obliterative, without osteoplastic	51	14	NEUROSURGERY	OTOLARYNGOLOGY	04
31084	Sinusotomy frontal; obliterative, with osteoplastic flap,	13	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31085	Sinusotomy frontal; obliterative, with osteoplastic flap,	90	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31086	Sinusotomy frontal; nonobliterative, with osteoplastic	25	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31087	Sinusotomy frontal; nonobliterative, with osteoplastic	20	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31230	Maxillectomy; with orbital exenteration (en bloc)	44	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31293	Nasal/sinus endoscopy, surgical; with medial orbital	74	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31294	Nasal/sinus endoscopy, surgical; with optic nerve	14	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31320	Laryngotomy (thyrotomy, laryngofissure); diagnostic	7	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31367	Laryngectomy; subtotal supraglottic, without radical	90	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31368	Laryngectomy; subtotal supraglottic, with radical neck	43	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31370	Partial laryngectomy (hemilaryngectomy); horizontal	69	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31375	Partial laryngectomy (hemilaryngectomy); laterovertical	52	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31380	Partial laryngectomy (hemilaryngectomy);	39	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31382	Partial laryngectomy (hemilaryngectomy); antero-latero-	58	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31390	Pharyngolaryngectomy, with radical neck dissection;	74	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31395	Pharyngolaryngectomy, with radical neck dissection;	64	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31420	Epiglottidectomy	42	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31512	Laryngoscopy, indirect; with removal of lesion	17	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04

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31520	Laryngoscopy direct, with or without tracheoscopy;	14	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31527	Laryngoscopy direct, with or without tracheoscopy; with	21	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31546	Laryngoscopy, direct, operative, with operating	24	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31560	Laryngoscopy, direct, operative, with arytenoidectomy;	25	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31580	Laryngoplasty; for laryngeal web, two stage, with keel	39	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31584	Laryngoplasty; with open reduction of fracture	9	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31587	Laryngoplasty, cricoid split	24	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31590	Laryngeal reinnervation by neuromuscular pedicle	5	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31595	Section recurrent laryngeal nerve, therapeutic	39	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31601	Tracheostomy, planned (separate procedure); younger	11	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31637	Bronchoscopy, rigid or flexible, with or without	74	29	PULMONARY DISEASE	PULMONARY DISEASE	29
31656	Bronchoscopy (rigid or flexible); with injection of	57	29	PULMONARY DISEASE	PULMONARY DISEASE	29
31715	Transtracheal injection for bronchography	8	29	PULMONARY DISEASE	PULMONARY DISEASE	29
31717	Catheterization with bronchial brush biopsy	53	11	INTERNAL MEDICINE	PULMONARY DISEASE	29
31755	Tracheoplasty; tracheopharyngeal fistulization, each	35	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31760	Tracheoplasty; intrathoracic	19	33	THORACIC SURGERY	THORACIC SURGERY	33
31766	Carinal reconstruction	5	33	THORACIC SURGERY	THORACIC SURGERY	33
31770	Bronchoplasty; graft repair	32	33	THORACIC SURGERY	THORACIC SURGERY	33
31775	Bronchoplasty; excision stenosis and anastomosis	25	29	PULMONARY DISEASE	THORACIC SURGERY	33
31781	Excision tracheal stenosis and anastomosis;	25	04	OTOLARYNGOLOGY	THORACIC SURGERY	33
31786	Excision of tracheal tumor or carcinoma; thoracic	10	04	OTOLARYNGOLOGY	THORACIC SURGERY	33
31800	Suture of tracheal wound or injury; cervical	72	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
31805	Suture of tracheal wound or injury; intrathoracic	26	33	THORACIC SURGERY	THORACIC SURGERY	33
32140	Thoracotomy, major; with cyst(s) removal, with or	84	33	THORACIC SURGERY	THORACIC SURGERY	33
32151	Thoracotomy, major; with removal of intrapulmonary	32	33	THORACIC SURGERY	THORACIC SURGERY	33
32200	Pneumonostomy; with open drainage of abscess or	91	33	THORACIC SURGERY	THORACIC SURGERY	33
32442	Removal of lung, total pneumonectomy; with resection	10	78	CARDIAC SURGERY	THORACIC SURGERY	33
32445	Removal of lung, total pneumonectomy; extrapleural	78	33	THORACIC SURGERY	THORACIC SURGERY	33
32504	Resection of apical lung tumor (eg, Pancoast tumor),	89	33	THORACIC SURGERY	THORACIC SURGERY	33
32603	Thoracoscopy, diagnostic (separate procedure);	49	78	CARDIAC SURGERY	THORACIC SURGERY	33
32604	Thoracoscopy, diagnostic (separate procedure);	35	78	CARDIAC SURGERY	THORACIC SURGERY	33
32605	Thoracoscopy, diagnostic (separate procedure);	45	33	THORACIC SURGERY	THORACIC SURGERY	33
32658	Thoracoscopy, surgical; with removal of clot or foreign	71	33	THORACIC SURGERY	THORACIC SURGERY	33
32660	Thoracoscopy, surgical; with total pericardiectomy	4	33	THORACIC SURGERY	THORACIC SURGERY	33
32661	Thoracoscopy, surgical; with excision of pericardial	35	33	THORACIC SURGERY	THORACIC SURGERY	33
32664	Thoracoscopy, surgical; with thoracic sympathectomy	81	33	THORACIC SURGERY	THORACIC SURGERY	33
32665	Thoracoscopy, surgical; with esophagomyotomy (Heller	59	02	GENERAL SURGERY	THORACIC SURGERY	33
32800	Repair lung hernia through chest wall	75	33	THORACIC SURGERY	THORACIC SURGERY	33
32810	Closure of chest wall following open flap drainage for	48	33	THORACIC SURGERY	THORACIC SURGERY	33
32820	Major reconstruction, chest wall (posttraumatic)	34	33	THORACIC SURGERY	THORACIC SURGERY	33

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32852	Lung transplant, single; with cardiopulmonary bypass	22	78	CARDIAC SURGERY	CARDIAC SURGERY	78
32905	Thoracoplasty, Schede type or extrapleural (all stages);	35	33	THORACIC SURGERY	THORACIC SURGERY	33
32906	Thoracoplasty, Schede type or extrapleural (all stages);	40	33	THORACIC SURGERY	THORACIC SURGERY	33
32940	Pneumonolysis, extraperiosteal, including filling or	44	33	THORACIC SURGERY	THORACIC SURGERY	33
32960	Pneumothorax, therapeutic, intrapleural injection of air	77	33	THORACIC SURGERY	DIAGNOSTIC RADIOLOGY	30
33011	Pericardiocentesis; subsequent	82	06	CARDIOLOGY	CARDIOLOGY	06
33050	Excision of pericardial cyst or tumor	96	33	THORACIC SURGERY	THORACIC SURGERY	33
33130	Resection of external cardiac tumor	32	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33140	Transmyocardial laser revascularization, by	72	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33236	Removal of permanent epicardial pacemaker and	74	33	THORACIC SURGERY	CARDIAC SURGERY	78
33237	Removal of permanent epicardial pacemaker and	82	06	CARDIOLOGY	CARDIAC SURGERY	78
33238	Removal of permanent transvenous electrode(s) by	97	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33250	Operative ablation of supraventricular arrhythmogenic	21	33	THORACIC SURGERY	CARDIAC SURGERY	78
33255	Operative tissue ablation and reconstruction of atria,	90	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33310	Cardiotomy, exploratory (includes removal of foreign	71	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33321	Suture repair of aorta or great vessels; with shunt	4	33	THORACIC SURGERY	CARDIAC SURGERY	78
33330	Insertion of graft, aorta or great vessels; without shunt,	36	02	GENERAL SURGERY	CARDIAC SURGERY	78
33335	Insertion of graft, aorta or great vessels; with	97	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33401	Valvuloplasty, aortic valve; open, with inflow occlusion	4	33	THORACIC SURGERY	CARDIAC SURGERY	78
33403	Valvuloplasty, aortic valve; using transventricular	8	33	THORACIC SURGERY	CARDIAC SURGERY	78
33404	Construction of apical-aortic conduit	73	33	THORACIC SURGERY	CARDIAC SURGERY	78
33412	Replacement, aortic valve; with transventricular aortic	32	33	THORACIC SURGERY	CARDIAC SURGERY	78
33413	Replacement, aortic valve; by translocation of	9	33	THORACIC SURGERY	CARDIAC SURGERY	78
33414	Repair of left ventricular outflow tract obstruction by	72	33	THORACIC SURGERY	CARDIAC SURGERY	33
33415	Resection or incision of subvalvular tissue for discrete	97	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33420	Valvotomy, mitral valve; closed heart	21	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33422	Valvotomy, mitral valve; open heart, with	55	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33460	Valvectomy, tricuspid valve, with cardiopulmonary	44	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33468	Tricuspid valve repositioning and plication for Ebstein	10	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33470	Valvotomy, pulmonary valve, closed heart;	3	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33474	Valvotomy, pulmonary valve, open heart; with	6	77	VASCULAR SURGERY	CARDIAC SURGERY	78
33475	Replacement, pulmonary valve	71	33	THORACIC SURGERY	CARDIAC SURGERY	78
33476	Right ventricular resection for infundibular stenosis,	5	33	THORACIC SURGERY	CARDIAC SURGERY	78
33478	Outflow tract augmentation (gusset), with or without	20	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33496	Repair of non-structural prosthetic valve dysfunction	76	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33500	Repair of coronary arteriovenous or arteriocardiac	36	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33501	Repair of coronary arteriovenous or arteriocardiac	60	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33502	Repair of anomalous coronary artery from pulmonary	80	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33503	Repair of anomalous coronary artery from pulmonary	16	06	CARDIOLOGY	CARDIAC SURGERY	78
33504	Repair of anomalous coronary artery from pulmonary	8	78	CARDIAC SURGERY	CARDIAC SURGERY	78

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33505	Repair of anomalous coronary artery from pulmonary	4	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33506	Repair of anomalous coronary artery from pulmonary	5	33	THORACIC SURGERY	CARDIAC SURGERY	78
33507	Repair of anomalous (eg, intramural) aortic origin of	19	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33600	Closure of atrioventricular valve (mitral or tricuspid) by	5	33	THORACIC SURGERY	CARDIAC SURGERY	78
33602	Closure of semilunar valve (aortic or pulmonary) by	11	02	GENERAL SURGERY	CARDIAC SURGERY	78
33606	Anastomosis of pulmonary artery to aorta (Damus-	1	33	THORACIC SURGERY	CARDIAC SURGERY	78
33608	Repair of complex cardiac anomaly other than	10	33	THORACIC SURGERY	CARDIAC SURGERY	78
33610	Repair of complex cardiac anomalies (eg, single	1	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33611	Repair of double outlet right ventricle with	2	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33612	Repair of double outlet right ventricle with	3	33	THORACIC SURGERY	CARDIAC SURGERY	78
33615	Repair of complex cardiac anomalies (eg, tricuspid	29	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33617	Repair of complex cardiac anomalies (eg, single	7	33	THORACIC SURGERY	CARDIAC SURGERY	78
33619	Repair of single ventricle with aortic outflow obstruction	1	02	GENERAL SURGERY	CARDIAC SURGERY	78
33645	Direct or patch closure, sinus venosus, with or without	42	33	THORACIC SURGERY	CARDIAC SURGERY	78
33647	Repair of atrial septal defect and ventricular septal	39	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33660	Repair of incomplete or partial atrioventricular canal	46	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33665	Repair of intermediate or transitional atrioventricular	1	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33670	Repair of complete atrioventricular canal, with or	1	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33675	Closure of multiple ventricular septal defects;	3	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33684	Closure of single ventricular septal defect, with or	3	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33688	Closure of single ventricular septal defect, with or	2	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33690	Banding of pulmonary artery	6	33	THORACIC SURGERY	CARDIAC SURGERY	78
33692	Complete repair tetralogy of Fallot without pulmonary	1	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33697	Complete repair tetralogy of Fallot with pulmonary	5	06	CARDIOLOGY	CARDIAC SURGERY	78
33702	Repair sinus of Valsalva fistula, with cardiopulmonary	10	33	THORACIC SURGERY	CARDIAC SURGERY	78
33710	Repair sinus of Valsalva fistula, with cardiopulmonary	2	06	CARDIOLOGY	CARDIAC SURGERY	78
33720	Repair sinus of Valsalva aneurysm, with	41	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33722	Closure of aortico-left ventricular tunnel	1	02	GENERAL SURGERY	CARDIAC SURGERY	78
33724	Repair of isolated partial anomalous pulmonary venous	10	33	THORACIC SURGERY	CARDIAC SURGERY	78
33730	Complete repair of anomalous pulmonary venous	5	33	THORACIC SURGERY	CARDIAC SURGERY	78
33732	Repair of cor triatriatum or supravalvular mitral ring by	4	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33736	Atrial septectomy or septostomy; open heart with	16	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33737	Atrial septectomy or septostomy; open heart, with	1	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33750	Shunt; subclavian to pulmonary artery (Blalock-Taussig	2	06	CARDIOLOGY	CARDIAC SURGERY	78
33755	Shunt; ascending aorta to pulmonary artery (Waterston	0	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33764	Shunt; central, with prosthetic graft	4	11	INTERNAL MEDICINE	CARDIAC SURGERY	78
33766	Shunt; superior vena cava to pulmonary artery for flow	3	02	GENERAL SURGERY	CARDIAC SURGERY	78
33767	Shunt; superior vena cava to pulmonary artery for flow	5	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33770	Repair of transposition of the great arteries with	1	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33774	Repair of transposition of the great arteries, atrial baffle	35	78	CARDIAC SURGERY	CARDIAC SURGERY	78

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33786	Total repair, truncus arteriosus (Rastelli type operation)	1	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33800	Aortic suspension (aortopexy) for tracheal decompression (eg, for tracheomalacia) (separate procedure)	6	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33802	Division of aberrant vessel (vascular ring);	4	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33803	Division of aberrant vessel (vascular ring); with	3	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33813	Obliteration of aortopulmonary septal defect; without	3	33	THORACIC SURGERY	CARDIAC SURGERY	78
33814	Obliteration of aortopulmonary septal defect; with	15	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33820	Repair of patent ductus arteriosus; by ligation	21	33	THORACIC SURGERY	CARDIAC SURGERY	78
33824	Repair of patent ductus arteriosus; by division, 18	4	33	THORACIC SURGERY	CARDIAC SURGERY	78
33840	Excision of coarctation of aorta, with or without	3	33	THORACIC SURGERY	CARDIAC SURGERY	78
33845	Excision of coarctation of aorta, with or without	5	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33851	Excision of coarctation of aorta, with or without	3	02	GENERAL SURGERY	CARDIAC SURGERY	78
33852	Repair of hypoplastic or interrupted aortic arch using	4	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33853	Repair of hypoplastic or interrupted aortic arch using	14	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33886	Placement of distal extension prosthesis(s) delayed	59	77	VASCULAR SURGERY	VASCULAR SURGERY	77
33889	Open subclavian to carotid artery transposition	39	77	VASCULAR SURGERY	VASCULAR SURGERY	77
33891	Bypass graft, with other than vein, transcervical	16	77	VASCULAR SURGERY	VASCULAR SURGERY	77
33910	Pulmonary artery embolectomy; with cardiopulmonary	92	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33915	Pulmonary artery embolectomy; without	5	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33916	Pulmonary endarterectomy, with or without	50	06	CARDIOLOGY	CARDIAC SURGERY	78
33917	Repair of pulmonary artery stenosis by reconstruction	44	33	THORACIC SURGERY	CARDIAC SURGERY	78
33920	Repair of pulmonary atresia with ventricular septal	2	78	CARDIAC SURGERY	CARDIAC SURGERY	78
33922	Transection of pulmonary artery with cardiopulmonary	8	33	THORACIC SURGERY	CARDIAC SURGERY	78
33924	Ligation and takedown of a systemic-to-pulmonary	4	02	GENERAL SURGERY	CARDIAC SURGERY	78
33925	Repair of pulmonary artery arborization anomalies by	3	33	THORACIC SURGERY	CARDIAC SURGERY	78
33926	Repair of pulmonary artery arborization anomalies by	1	01	GENERAL PRACTICE	CARDIAC SURGERY	78
33935	Heart-lung transplant with recipient cardiectomy-	10	33	THORACIC SURGERY	CARDIAC SURGERY	78
33960	Prolonged extracorporeal circulation for	53	78	CARDIAC SURGERY	THORACIC SURGERY	33
33974	Removal of intra-aortic balloon assist device from the	85	06	CARDIOLOGY	CARDIAC SURGERY	78
33976	Insertion of ventricular assist device; extracorporeal,	71	78	CARDIAC SURGERY	THORACIC SURGERY	33
33978	Removal of ventricular assist device; extracorporeal,	25	78	CARDIAC SURGERY	CARDIAC SURGERY	78
34051	Embolectomy or thrombectomy, with or without	35	78	CARDIAC SURGERY	CARDIAC SURGERY	78
34401	Thrombectomy, direct or with catheter; vena cava, iliac	81	02	GENERAL SURGERY	VASCULAR SURGERY	77
34451	Thrombectomy, direct or with catheter; vena cava, iliac,	53	77	VASCULAR SURGERY	VASCULAR SURGERY	77
34471	Thrombectomy, direct or with catheter; subclavian vein,	35	11	INTERNAL MEDICINE	VASCULAR SURGERY	77
34501	Valvuloplasty, femoral vein	86	77	VASCULAR SURGERY	VASCULAR SURGERY	77
34510	Venous valve transposition, any vein donor	13	02	GENERAL SURGERY	GENERAL SURGERY	02
34520	Cross-over vein graft to venous system	47	77	VASCULAR SURGERY	VASCULAR SURGERY	77

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34530	Saphenopopliteal vein anastomosis	8	77	VASCULAR SURGERY	VASCULAR SURGERY	77
34806	Transcatheter placement of wireless physiologic	33	77	VASCULAR SURGERY	VASCULAR SURGERY	77
34830	Open repair of infrarenal aortic aneurysm or dissection,	60	77	VASCULAR SURGERY	VASCULAR SURGERY	77
34831	Open repair of infrarenal aortic aneurysm or dissection,	64	77	VASCULAR SURGERY	Dominant specialty providing this service	77
34832	Open repair of infrarenal aortic aneurysm or dissection,	61	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35002	Direct repair of aneurysm, pseudoaneurysm, or	15	02	GENERAL SURGERY	VASCULAR SURGERY	77
35005	Direct repair of aneurysm, pseudoaneurysm, or	1	13	NEUROLOGY	VASCULAR SURGERY	77
35021	Direct repair of aneurysm, pseudoaneurysm, or	59	33	THORACIC SURGERY	CARDIAC SURGERY	78
35022	Direct repair of aneurysm, pseudoaneurysm, or	7	78	CARDIAC SURGERY	CARDIAC SURGERY	78
35111	Direct repair of aneurysm, pseudoaneurysm, or	66	02	GENERAL SURGERY	GENERAL SURGERY	02
35112	Direct repair of aneurysm, pseudoaneurysm, or	12	02	GENERAL SURGERY	GENERAL SURGERY	02
35122	Direct repair of aneurysm, pseudoaneurysm, or	32	02	GENERAL SURGERY	GENERAL SURGERY	02
35152	Direct repair of aneurysm, pseudoaneurysm, or	39	77	VASCULAR SURGERY	GENERAL SURGERY	02
35180	Repair, congenital arteriovenous fistula; head and neck	4	77	VASCULAR SURGERY	THORACIC SURGERY	33
35182	Repair, congenital arteriovenous fistula; thorax and	5	78	CARDIAC SURGERY	THORACIC SURGERY	33
35188	Repair, acquired or traumatic arteriovenous fistula;	23	77	VASCULAR SURGERY	GENERAL SURGERY	02
35189	Repair, acquired or traumatic arteriovenous fistula;	34	77	VASCULAR SURGERY	GENERAL SURGERY	02
35246	Repair blood vessel with vein graft; intrathoracic,	29	78	CARDIAC SURGERY	CARDIAC SURGERY	78
35271	Repair blood vessel with graft other than vein;	87	78	CARDIAC SURGERY	CARDIAC SURGERY	78
35276	Repair blood vessel with graft other than vein;	32	33	THORACIC SURGERY	CARDIAC SURGERY	78
35306	Thromboendarterectomy, including patch graft, if	46	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35311	Thromboendarterectomy, including patch graft, if	31	33	THORACIC SURGERY	VASCULAR SURGERY	77
35361	Thromboendarterectomy, including patch graft, if	71	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35363	Thromboendarterectomy, including patch graft, if	70	78	CARDIAC SURGERY	VASCULAR SURGERY	77
35480	Transluminal peripheral atherectomy, open; renal or	24	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35481	Transluminal peripheral atherectomy, open; aortic	45	33	THORACIC SURGERY	THORACIC SURGERY	33
35482	Transluminal peripheral atherectomy, open; iliac	51	02	GENERAL SURGERY	THORACIC SURGERY	33
35484	Transluminal peripheral atherectomy, open;	50	02	GENERAL SURGERY	GENERAL SURGERY	02
35491	Transluminal peripheral atherectomy, percutaneous;	33	77	VASCULAR SURGERY	CARDIOLOGY	06
35508	Bypass graft, with vein; carotid-vertebral	19	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35509	Bypass graft, with vein; carotid-contralateral carotid	39	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35510	Bypass graft, with vein; carotid-brachial	20	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35511	Bypass graft, with vein; subclavian-subclavian	11	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35512	Bypass graft, with vein; subclavian-brachial	22	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35515	Bypass graft, with vein; subclavian-vertebral	2	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35516	Bypass graft, with vein; subclavian-axillary	12	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35518	Bypass graft, with vein; axillary-axillary	15	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35521	Bypass graft, with vein; axillary-femoral	53	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35526	Bypass graft, with vein; aortosubclavian or carotid	10	78	CARDIAC SURGERY	VASCULAR SURGERY	77
35533	Bypass graft, with vein; axillary-femoral-femoral	53	02	GENERAL SURGERY	VASCULAR SURGERY	77

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35536	Bypass graft, with vein; splenorenal	26	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35537	Bypass graft, with vein; aortoiliac	16	02	GENERAL SURGERY	VASCULAR SURGERY	77
35538	Bypass graft, with vein; aortobi-iliac	57	02	GENERAL SURGERY	VASCULAR SURGERY	77
35539	Bypass graft, with vein; aortofemoral	35	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35548	Bypass graft, with vein; aortoiliofemoral, unilateral	13	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35549	Bypass graft, with vein; aortoiliofemoral, bilateral	10	02	GENERAL SURGERY	VASCULAR SURGERY	77
35551	Bypass graft, with vein; aortofemoral-popliteal	31	33	THORACIC SURGERY	VASCULAR SURGERY	77
35563	Bypass graft, with vein; ilioiliac	14	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35612	Bypass graft, with other than vein; subclavian-	52	02	GENERAL SURGERY	VASCULAR SURGERY	77
35616	Bypass graft, with other than vein; subclavian-axillary	58	02	GENERAL SURGERY	VASCULAR SURGERY	77
35623	Bypass graft, with other than vein; axillary-popliteal or -	79	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35636	Bypass graft, with other than vein; splenorenal (splenic	17	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35642	Bypass graft, with other than vein; carotid-vertebral	4	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35645	Bypass graft, with other than vein; subclavian-vertebral	4	02	GENERAL SURGERY	VASCULAR SURGERY	77
35651	Bypass graft, with other than vein; aortofemoral-	76	02	GENERAL SURGERY	VASCULAR SURGERY	77
35683	Bypass graft; autogenous composite, three or more	76	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35691	Transposition and/or reimplantation; vertebral to carotid	60	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35693	Transposition and/or reimplantation; vertebral to	7	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35694	Transposition and/or reimplantation; subclavian to	55	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35695	Transposition and/or reimplantation; carotid to	27	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35870	Repair of graft-enteric fistula	80	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35884	Revision, femoral anastomosis of synthetic arterial	51	77	VASCULAR SURGERY	VASCULAR SURGERY	77
35905	Excision of infected graft; thorax	67	77	VASCULAR SURGERY	VASCULAR SURGERY	77
36261	Revision of implanted intra-arterial infusion pump	5	02	GENERAL SURGERY	GENERAL SURGERY	02
36400	Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; femoral or jugular vein	29	93	EMERGENCY MEDICINE	PEDIATRIC MEDICINE	37
36405	Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein	14	11	INTERNAL MEDICINE	PEDIATRIC MEDICINE	37
36406	Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; other vein	8	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37
36420	Venipuncture, cutdown; younger than age 1 year	2	77	VASCULAR SURGERY	EMERGENCY MEDICINE	93
36440	Push transfusion, blood, 2 years or younger	3	30	DIAGNOSTIC RADIOLOGY	PEDIATRIC MEDICINE	37

RUC Recommended Dominant Specialty for PLI Methodology

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36450	Exchange transfusion, blood; newborn	5	83	HEMATOLOGY/ONCOLOGY	PEDIATRIC MEDICINE	37
36460	Transfusion, intrauterine, fetal	3	77	VASCULAR SURGERY	OB-GYN	16
36468	Single or multiple injections of sclerosing solutions,	42	02	GENERAL SURGERY	GENERAL SURGERY	02
36510	Catheterization of umbilical vein for diagnosis or	11	29	PULMONARY DISEASE	PEDIATRIC MEDICINE	37
36557	Insertion of tunneled centrally inserted central venous	79	02	GENERAL SURGERY	GENERAL SURGERY	02
36560	Insertion of tunneled centrally inserted central venous	23	02	GENERAL SURGERY	GENERAL SURGERY	02
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age	45	30	DIAGNOSTIC RADIOLOGY	INTERVENTIONAL RADIOLOGY	94
36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age	2	30	DIAGNOSTIC RADIOLOGY	INTERVENTIONAL RADIOLOGY	94
36583	Replacement, complete, of a tunneled centrally	93	02	GENERAL SURGERY	GENERAL SURGERY	02
36660	Catheterization, umbilical artery, newborn, for	4	93	EMERGENCY MEDICINE	PEDIATRIC MEDICINE	37
36835	Insertion of Thomas shunt (separate procedure)	27	33	THORACIC SURGERY	THORACIC SURGERY	33
37140	Venous anastomosis, open; portocaval	46	02	GENERAL SURGERY	GENERAL SURGERY	02
37145	Venous anastomosis, open; renoportal	4	18	OPHTHALMOLOGY	GENERAL SURGERY	02
37160	Venous anastomosis, open; caval-mesenteric	10	02	GENERAL SURGERY	GENERAL SURGERY	02
37180	Venous anastomosis, open; splenorenal, proximal	5	02	GENERAL SURGERY	GENERAL SURGERY	02
37181	Venous anastomosis, open; splenorenal, distal	10	02	GENERAL SURGERY	GENERAL SURGERY	02
37195	Thrombolysis, cerebral, by intravenous infusion	27	13	NEUROLOGY	NEUROLOGY	13
37606	Ligation; internal or common carotid artery, with	21	02	GENERAL SURGERY	NEUROSURGERY	14
37615	Ligation, major artery (eg, post-traumatic, rupture);	67	02	GENERAL SURGERY	GENERAL SURGERY	02
37616	Ligation, major artery (eg, post-traumatic, rupture);	75	78	CARDIAC SURGERY	CARDIAC SURGERY	78
37660	Ligation of common iliac vein	53	77	VASCULAR SURGERY	GENERAL SURGERY	02
37788	Penile revascularization, artery, with or without vein	1	34	UROLOGY	UROLOGY	34
37790	Penile venous occlusive procedure	4	02	GENERAL SURGERY	UROLOGY	34
38101	Splenectomy; partial (separate procedure)	43	02	GENERAL SURGERY	GENERAL SURGERY	02
38200	Injection procedure for splenoportography	27	90	MEDICAL ONCOLOGY	DIAGNOSTIC RADIOLOGY	30
38242	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions	52	83	HEMATOLOGY/ONCOLOGY	HEMATOLOGY	82
38380	Suture and/or ligation of thoracic duct; cervical	33	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
38382	Suture and/or ligation of thoracic duct; abdominal	8	77	VASCULAR SURGERY	THORACIC SURGERY	33
38555	Excision of cystic hygroma, axillary or cervical; with	87	33	THORACIC SURGERY	GENERAL SURGERY	02
38794	Cannulation, thoracic duct	7	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
39200	Excision of mediastinal cyst	67	33	THORACIC SURGERY	THORACIC SURGERY	33
39503	Repair, neonatal diaphragmatic hernia, with or without	5	02	GENERAL SURGERY	GENERAL SURGERY	02

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39530	Repair, diaphragmatic hernia (esophageal hiatal);	89	02	GENERAL SURGERY	GENERAL SURGERY	02
39531	Repair, diaphragmatic hernia (esophageal hiatal);	8	02	GENERAL SURGERY	GENERAL SURGERY	02
39540	Repair, diaphragmatic hernia (other than neonatal),	94	02	GENERAL SURGERY	GENERAL SURGERY	02
40527	Excision of lip; full thickness, reconstruction with cross	94	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
40700	Plastic repair of cleft lip/nasal deformity; primary, partial	10	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
40701	Plastic repair of cleft lip/nasal deformity; primary	4	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
40720	Plastic repair of cleft lip/nasal deformity; secondary, by	11	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
40761	Plastic repair of cleft lip/nasal deformity; with cross lip	18	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
40805	Removal of embedded foreign body, vestibule of	61	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
40806	Incision of labial frenum (frenotomy)	18	26	PSYCHIATRY	ORAL SURGERY	19
40840	Vestibuloplasty; anterior	43	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
40842	Vestibuloplasty; posterior, unilateral	8	19	ORAL SURGERY (DENTISTS	OTOLARYNGOLOGY	04
40843	Vestibuloplasty; posterior, bilateral	3	19	ORAL SURGERY (DENTISTS	OTOLARYNGOLOGY	04
40844	Vestibuloplasty; entire arch	9	85	MAXILLOFACIAL SURGERY	OTOLARYNGOLOGY	04
40845	Vestibuloplasty; complex (including ridge extension,	83	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
41005	Intraoral incision and drainage of abscess, cyst, or	47	04	OTOLARYNGOLOGY	ORAL SURGERY	19
41006	Intraoral incision and drainage of abscess, cyst, or	54	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
41007	Intraoral incision and drainage of abscess, cyst, or	43	04	OTOLARYNGOLOGY	ORAL SURGERY	19
41010	Incision of lingual frenum (frenotomy)	23	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
41015	Extraoral incision and drainage of abscess, cyst, or	45	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
41016	Extraoral incision and drainage of abscess, cyst, or	88	19	ORAL SURGERY (DENTISTS	MAXILLOFACIAL SURGERY	85
41018	Extraoral incision and drainage of abscess, cyst, or	56	85	MAXILLOFACIAL SURGERY	ORAL SURGERY	19
41115	Excision of lingual frenum (frenectomy)	52	19	ORAL SURGERY (DENTISTS	OTOLARYNGOLOGY	04
41140	Glossectomy; complete or total, with or without	17	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
41145	Glossectomy; complete or total, with or without	27	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
41251	Repair of laceration 2.5 cm or less; posterior one-third	33	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	93
41500	Fixation of tongue, mechanical, other than suture (eg,	9	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
41510	Suture of tongue to lip for micrognathia (Douglas type	3	02	GENERAL SURGERY	OTOLARYNGOLOGY	04
41520	Frenoplasty (surgical revision of frenum, eg, with Z-	46	19	ORAL SURGERY (DENTISTS	OTOLARYNGOLOGY	04
41530	Submucosal ablation of the tongue base,	8	04	OTOLARYNGOLOGY	MAXILLOFACIAL SURGERY	85
41805	Removal of embedded foreign body from dentoalveolar	53	19	ORAL SURGERY (DENTISTS	MAXILLOFACIAL SURGERY	85
41806	Removal of embedded foreign body from dentoalveolar	98	19	ORAL SURGERY (DENTISTS	MAXILLOFACIAL SURGERY	85
41820	Gingivectomy, excision gingiva, each quadrant	2	04	OTOLARYNGOLOGY	ORAL SURGERY	19
41822	Excision of fibrous tuberosities, dentoalveolar	6	19	ORAL SURGERY (DENTISTS	ORAL SURGERY	19
41823	Excision of osseous tuberosities, dentoalveolar	27	85	MAXILLOFACIAL SURGERY	ORAL SURGERY	19
41828	Excision of hyperplastic alveolar mucosa, each	51	19	ORAL SURGERY (DENTISTS	MAXILLOFACIAL SURGERY	85
41830	Alveolectomy, including curettage of osteitis or	95	19	ORAL SURGERY (DENTISTS	MAXILLOFACIAL SURGERY	85
41850	Destruction of lesion (except excision), dentoalveolar	7	04	OTOLARYNGOLOGY	ORAL SURGERY	19
41872	Gingivoplasty, each quadrant (specify)	1	85	MAXILLOFACIAL SURGERY	ORAL SURGERY	19
42000	Drainage of abscess of palate, uvula	87	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04

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42180	Repair, laceration of palate; up to 2 cm	16	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42182	Repair, laceration of palate; over 2 cm or complex	23	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42200	Palatoplasty for cleft palate, soft and/or hard palate	14	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
42205	Palatoplasty for cleft palate, with closure of alveolar	3	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
42210	Palatoplasty for cleft palate, with closure of alveolar	9	85	MAXILLOFACIAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
42215	Palatoplasty for cleft palate; major revision	6	85	MAXILLOFACIAL SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
42220	Palatoplasty for cleft palate; secondary lengthening	1	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
42225	Palatoplasty for cleft palate; attachment pharyngeal	13	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
42226	Lengthening of palate, and pharyngeal flap	6	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42227	Lengthening of palate, with island flap	3	85	MAXILLOFACIAL SURGERY	OTOLARYNGOLOGY	04
42235	Repair of anterior palate, including vomer flap	11	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42260	Repair of nasolabial fistula	17	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42280	Maxillary impression for palatal prosthesis	68	19	ORAL SURGERY (DENTISTS	MAXILLOFACIAL SURGERY	85
42281	Insertion of pin-retained palatal prosthesis	53	04	OTOLARYNGOLOGY	MAXILLOFACIAL SURGERY	85
42310	Drainage of abscess; submaxillary or sublingual,	90	04	OTOLARYNGOLOGY	MAXILLOFACIAL SURGERY	85
42320	Drainage of abscess; submaxillary, external	65	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42340	Sialolithotomy; parotid, extraoral or complicated	76	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42408	Excision of sublingual salivary cyst (ranula)	86	04	OTOLARYNGOLOGY	MAXILLOFACIAL SURGERY	85
42409	Marsupialization of sublingual salivary cyst (ranula)	73	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42505	Plastic repair of salivary duct, sialodochoplasty;	90	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42507	Parotid duct diversion, bilateral (Wilke type procedure);	13	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42508	Parotid duct diversion, bilateral (Wilke type procedure);	4	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42510	Parotid duct diversion, bilateral (Wilke type procedure);	5	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42600	Closure salivary fistula	20	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42665	Ligation salivary duct, intraoral	16	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42725	Incision and drainage abscess; retropharyngeal or	76	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42810	Excision branchial cleft cyst or vestige, confined to skin	83	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42820	Tonsillectomy and adenoidectomy; younger than age	21	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42825	Tonsillectomy, primary or secondary; younger than age	4	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42830	Adenoidectomy, primary; younger than age 12	4	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42836	Adenoidectomy, secondary; age 12 or over	22	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42844	Radical resection of tonsil, tonsillar pillars, and/or	84	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42845	Radical resection of tonsil, tonsillar pillars, and/or	65	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42860	Excision of tonsil tags	76	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42894	Resection of pharyngeal wall requiring closure with	87	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42900	Suture pharynx for wound or injury	44	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42955	Pharyngostomy (fistulization of pharynx, external for	31	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42971	Control of nasopharyngeal hemorrhage, primary or	12	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
42972	Control of nasopharyngeal hemorrhage, primary or	24	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
43020	Esophagotomy, cervical approach, with removal of	18	33	THORACIC SURGERY	GENERAL SURGERY	02

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43045	Esophagotomy, thoracic approach, with removal of	12	33	THORACIC SURGERY	THORACIC SURGERY	33
43100	Excision of lesion, esophagus, with primary repair;	43	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
43101	Excision of lesion, esophagus, with primary repair;	43	02	GENERAL SURGERY	THORACIC SURGERY	33
43108	Total or near total esophagectomy, without	9	02	GENERAL SURGERY	GENERAL SURGERY	02
43113	Total or near total esophagectomy, with thoracotomy;	10	33	THORACIC SURGERY	THORACIC SURGERY	33
43116	Partial esophagectomy, cervical, with free intestinal	13	04	OTOLARYNGOLOGY	THORACIC SURGERY	33
43118	Partial esophagectomy, distal two-thirds, with	12	02	GENERAL SURGERY	ENERAL SURGERY	02
43121	Partial esophagectomy, distal two-thirds, with	42	33	THORACIC SURGERY	THORACIC SURGERY	33
43123	Partial esophagectomy, thoracoabdominal or	24	02	GENERAL SURGERY	THORACIC SURGERY	02
43124	Total or partial esophagectomy, without reconstruction	59	02	GENERAL SURGERY	THORACIC SURGERY	33
43257	Upper gastrointestinal endoscopy including esophagus,	25	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
43300	Esophagoplasty (plastic repair or reconstruction),	75	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
43305	Esophagoplasty (plastic repair or reconstruction),	77	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
43310	Esophagoplasty (plastic repair or reconstruction),	59	33	THORACIC SURGERY	THORACIC SURGERY	33
43312	Esophagoplasty (plastic repair or reconstruction),	14	33	THORACIC SURGERY	THORACIC SURGERY	33
43312	Esophagoplasty (plastic repair or reconstruction),	14	33	THORACIC SURGERY	THORACIC SURGERY	33
43313	Esophagoplasty for congenital defect (plastic repair or	2	08	FAMILY PRACTICE	THORACIC SURGERY	33
43314	Esophagoplasty for congenital defect (plastic repair or	1	04	OTOLARYNGOLOGY	THORACIC SURGERY	33
43320	Esophagogastrostomy (cardioplasty), with or without	95	02	GENERAL SURGERY	GENERAL SURGERY	02
43325	Esophagogastric fundoplasty; with fundic patch (Thal-	85	02	GENERAL SURGERY	GENERAL SURGERY	02
43331	Esophagomyotomy (Heller type); thoracic approach	66	33	THORACIC SURGERY	THORACIC SURGERY	33
43340	Esophagojejunostomy (without total gastrectomy);	26	02	GENERAL SURGERY	GENERAL SURGERY	02
43341	Esophagojejunostomy (without total gastrectomy);	7	33	THORACIC SURGERY	THORACIC SURGERY	33
43350	Esophagostomy, fistulization of esophagus, external;	5	02	GENERAL SURGERY	GENERAL SURGERY	02
43351	Esophagostomy, fistulization of esophagus, external;	13	78	CARDIAC SURGERY	THORACIC SURGERY	33
43352	Esophagostomy, fistulization of esophagus, external;	83	33	THORACIC SURGERY	THORACIC SURGERY	33
43360	Gastrointestinal reconstruction for previous	30	02	GENERAL SURGERY	GENERAL SURGERY	02
43361	Gastrointestinal reconstruction for previous	24	02	GENERAL SURGERY	GENERAL SURGERY	02
43400	Ligation, direct, esophageal varices	15	10	GASTROENTEROLOGY	GENERAL SURGERY	02
43401	Transection of esophagus with repair, for esophageal	3	02	GENERAL SURGERY	GENERAL SURGERY	02
43405	Ligation or stapling at gastroesophageal junction for	38	02	GENERAL SURGERY	GENERAL SURGERY	02
43410	Suture of esophageal wound or injury; cervical	81	33	THORACIC SURGERY	GENERAL SURGERY	02
43420	Closure of esophagostomy or fistula; cervical approach	56	04	OTOLARYNGOLOGY	GENERAL SURGERY	02
43425	Closure of esophagostomy or fistula; transthoracic or	32	02	GENERAL SURGERY	GENERAL SURGERY	02
43460	Esophagogastric tamponade, with balloon (Sengstaken	52	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
43496	Free jejunum transfer with microvascular anastomosis	20	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
43502	Gastrotomy; with suture repair of pre-existing	55	02	GENERAL SURGERY	GENERAL SURGERY	02
43510	Gastrotomy; with esophageal dilation and insertion of	52	02	GENERAL SURGERY	GENERAL SURGERY	02
43634	Gastrectomy, partial, distal; with formation of intestinal	44	02	GENERAL SURGERY	GENERAL SURGERY	02
43641	Vagotomy including pyloroplasty, with or without	27	02	GENERAL SURGERY	GENERAL SURGERY	02

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43651	Laparoscopy, surgical; transection of vagus nerves,	14	02	GENERAL SURGERY	GENERAL SURGERY	02
43652	Laparoscopy, surgical; transection of vagus nerves,	11	02	GENERAL SURGERY	GENERAL SURGERY	02
43771	Laparoscopy, surgical, gastric restrictive procedure;	55	02	GENERAL SURGERY	GENERAL SURGERY	02
43772	Laparoscopy, surgical, gastric restrictive procedure;	47	02	GENERAL SURGERY	GENERAL SURGERY	02
43773	Laparoscopy, surgical, gastric restrictive procedure;	31	02	GENERAL SURGERY	GENERAL SURGERY	02
43810	Gastroduodenostomy	63	02	GENERAL SURGERY	GENERAL SURGERY	02
43831	Gastrostomy, open; neonatal, for feeding	23	02	GENERAL SURGERY	GENERAL SURGERY	02
43843	Gastric restrictive procedure, without gastric bypass,	53	02	GENERAL SURGERY	GENERAL SURGERY	02
43845	Gastric restrictive procedure with partial gastrectomy,	87	02	GENERAL SURGERY	GENERAL SURGERY	02
43847	Gastric restrictive procedure, with gastric bypass for	93	02	GENERAL SURGERY	GENERAL SURGERY	02
43850	Revision of gastroduodenal anastomosis	38	02	GENERAL SURGERY	GENERAL SURGERY	02
43855	Revision of gastroduodenal anastomosis	2	02	GENERAL SURGERY	GENERAL SURGERY	02
43865	Revision of gastrojejunal anastomosis	28	02	GENERAL SURGERY	GENERAL SURGERY	02
43886	Gastric restrictive procedure, open; revision of	43	02	GENERAL SURGERY	GENERAL SURGERY	02
43887	Gastric restrictive procedure, open; removal of	37	02	GENERAL SURGERY	GENERAL SURGERY	02
43888	Gastric restrictive procedure, open; removal and	41	02	GENERAL SURGERY	GENERAL SURGERY	02
44126	Enterectomy, resection of small intestine for congenital	80	02	GENERAL SURGERY	GENERAL SURGERY	02
44127	Enterectomy, resection of small intestine for congenital	9	02	GENERAL SURGERY	GENERAL SURGERY	02
44128	Enterectomy, resection of small intestine for congenital	10	02	GENERAL SURGERY	GENERAL SURGERY	02
44156	Colectomy, total, abdominal, with proctectomy; with	29	02	GENERAL SURGERY	GENERAL SURGERY	02
44157	Colectomy, total, abdominal, with proctectomy; with	85	02	GENERAL SURGERY	GENERAL SURGERY	02
44203	Laparoscopy, surgical; each additional small intestine	75	02	GENERAL SURGERY	GENERAL SURGERY	02
44211	Laparoscopy, surgical; colectomy, total, abdominal,	63	02	GENERAL SURGERY	GENERAL SURGERY	02
44316	Continent ileostomy (Kock procedure) (separate	30	02	GENERAL SURGERY	GENERAL SURGERY	02
44322	Colostomy or skin level cecostomy; with multiple	37	02	GENERAL SURGERY	GENERAL SURGERY	02
44379	Small intestinal endoscopy, enteroscopy beyond	18	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
44390	Colonoscopy through stoma; with removal of foreign	20	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
44397	Colonoscopy through stoma; with transendoscopic	8	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
44680	Intestinal plication (separate procedure)	79	02	GENERAL SURGERY	GENERAL SURGERY	02
44721	Backbench reconstruction of cadaver or living donor	1	72	PAIN MANAGEMENT	GENERAL SURGERY	02
45108	Anorectal myomectomy	76	02	GENERAL SURGERY	GENERAL SURGERY	02
45113	Proctectomy, partial, with rectal mucosectomy, ileoanal	66	02	GENERAL SURGERY	GENERAL SURGERY	02
45114	Proctectomy, partial, with anastomosis; abdominal and	53	02	GENERAL SURGERY	GENERAL SURGERY	02
45116	Proctectomy, partial, with anastomosis; transsacral	25	28	COLORECTAL	GENERAL SURGERY	02
45120	Proctectomy, complete (for congenital megacolon),	13	02	GENERAL SURGERY	GENERAL SURGERY	02
45121	Proctectomy, complete (for congenital megacolon),	22	02	GENERAL SURGERY	GENERAL SURGERY	02
45126	Pelvic exenteration for colorectal malignancy, with	83	02	GENERAL SURGERY	GENERAL SURGERY	02
45135	Excision of rectal procidentia, with anastomosis;	36	02	GENERAL SURGERY	GENERAL SURGERY	02
45136	Excision of ileoanal reservoir with ileostomy	48	02	GENERAL SURGERY	COLORECTAL SURGERY	28
45150	Division of stricture of rectum	52	28	COLORECTAL	GENERAL SURGERY	02

RUC Recommended Dominant Specialty for PLI Methodology

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45160	Excision of rectal tumor by proctotomy, transsacral or	81	02	GENERAL SURGERY	GENERAL SURGERY	02
45315	Proctosigmoidoscopy, rigid; with removal of multiple	98	02	GENERAL SURGERY	GENERAL SURGERY	02
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent	39	10	GASTROENTEROLOGY	GENERAL SURGERY	02
45392	Colonoscopy, flexible, proximal to splenic flexure; with	93	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
45397	Laparoscopy, surgical; proctectomy, combined	97	28	COLORECTAL	GENERAL SURGERY	02
45563	Exploration, repair, and presacral drainage for rectal	51	02	GENERAL SURGERY	GENERAL SURGERY	02
45805	Closure of rectovesical fistula; with colostomy	13	02	GENERAL SURGERY	GENERAL SURGERY	02
45820	Closure of rectourethral fistula;	77	28	COLORECTAL	GENERAL SURGERY	02
45825	Closure of rectourethral fistula; with colostomy	3	02	GENERAL SURGERY	GENERAL SURGERY	02
46210	Cryptectomy; single	22	02	GENERAL SURGERY	GENERAL SURGERY	02
46211	Cryptectomy; multiple (separate procedure)	36	02	GENERAL SURGERY	GENERAL SURGERY	02
46258	Hemorrhoidectomy, internal and external, simple; with	89	02	GENERAL SURGERY	GENERAL SURGERY	02
46612	Anoscopy; with removal of multiple tumors, polyps, or	89	02	GENERAL SURGERY	GENERAL SURGERY	02
46710	Repair of ileoanal pouch fistula/sinus (eg, perineal or	6	28	COLORECTAL	COLORECTAL SURGERY	28
46712	Repair of ileoanal pouch fistula/sinus (eg, perineal or	3	02	GENERAL SURGERY	GENERAL SURGERY	02
46715	Repair of low imperforate anus; with anoperineal fistula	2	02	GENERAL SURGERY	GENERAL SURGERY	02
46716	Repair of low imperforate anus; with transposition of	4	07	DERMATOLOGY	GENERAL SURGERY	02
46740	Repair of high imperforate anus with rectourethral or	4	02	GENERAL SURGERY	GENERAL SURGERY	02
46742	Repair of high imperforate anus with rectourethral or	1	02	GENERAL SURGERY	GENERAL SURGERY	02
46744	Repair of cloacal anomaly by anorectovaginoplasty and	4	28	COLORECTAL	GENERAL SURGERY	02
46754	Removal of Thiersch wire or suture, anal canal	36	02	GENERAL SURGERY	GENERAL SURGERY	02
46760	Sphincteroplasty, anal, for incontinence, adult; muscle	22	28	COLORECTAL	COLORECTAL SURGERY	28
46762	Sphincteroplasty, anal, for incontinence, adult;	29	28	COLORECTAL	COLORECTAL SURGERY	28
46937	Cryosurgery of rectal tumor; benign	19	10	GASTROENTEROLOGY	GENERAL SURGERY	02
46938	Cryosurgery of rectal tumor; malignant	8	02	GENERAL SURGERY	GENERAL SURGERY	02
47136	Liver allotransplantation; heterotopic, partial or whole,	1	02	GENERAL SURGERY	GENERAL SURGERY	02
47140	Donor hepatectomy (including cold preservation), from	5	02	GENERAL SURGERY	GENERAL SURGERY	02
47141	Donor hepatectomy (including cold preservation), from	4	02	GENERAL SURGERY	GENERAL SURGERY	02
47142	Donor hepatectomy (including cold preservation), from	20	02	GENERAL SURGERY	GENERAL SURGERY	02
47146	Backbench reconstruction of cadaver or living donor	44	02	GENERAL SURGERY	GENERAL SURGERY	02
47362	Management of liver hemorrhage; re-exploration of	88	02	GENERAL SURGERY	GENERAL SURGERY	02
47371	Laparoscopy, surgical, ablation of one or more liver	17	02	GENERAL SURGERY	GENERAL SURGERY	02
47381	Ablation, open, of one or more liver tumor(s);	16	02	GENERAL SURGERY	GENERAL SURGERY	02
47400	Hepaticotomy or hepaticostomy with exploration,	36	02	GENERAL SURGERY	GENERAL SURGERY	02
47425	Choledochotomy or choledochostomy with exploration,	34	02	GENERAL SURGERY	GENERAL SURGERY	02
47460	Transduodenal sphincterotomy or sphincteroplasty,	79	02	GENERAL SURGERY	GENERAL SURGERY	02
47560	Laparoscopy, surgical; with guided transhepatic	80	02	GENERAL SURGERY	GENERAL SURGERY	02
47561	Laparoscopy, surgical; with guided transhepatic	51	02	GENERAL SURGERY	GENERAL SURGERY	02
47570	Laparoscopy, surgical; cholecystoenterostomy	29	02	GENERAL SURGERY	GENERAL SURGERY	02
47700	Exploration for congenital atresia of bile ducts, without	19	02	GENERAL SURGERY	GENERAL SURGERY	02

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47701	Portoenterostomy (eg, Kasai procedure)	11	02	GENERAL SURGERY	GENERAL SURGERY	02
47712	Excision of bile duct tumor, with or without primary	44	02	GENERAL SURGERY	GENERAL SURGERY	02
47715	Excision of choledochal cyst	31	02	GENERAL SURGERY	GENERAL SURGERY	02
47721	Cholecystoenterostomy; with gastroenterostomy	48	02	GENERAL SURGERY	GENERAL SURGERY	02
47740	Cholecystoenterostomy; Roux-en-Y	67	02	GENERAL SURGERY	GENERAL SURGERY	02
47741	Cholecystoenterostomy; Roux-en-Y with	84	02	GENERAL SURGERY	GENERAL SURGERY	02
47765	Anastomosis, of intrahepatic ducts and gastrointestinal	41	02	GENERAL SURGERY	GENERAL SURGERY	02
47802	U-tube hepaticoenterostomy	9	02	GENERAL SURGERY	GENERAL SURGERY	02
48001	Placement of drains, peripancreatic, for acute	48	02	GENERAL SURGERY	GENERAL SURGERY	02
48020	Removal of pancreatic calculus	8	02	GENERAL SURGERY	GENERAL SURGERY	02
48145	Pancreatectomy, distal subtotal, with or without	83	02	GENERAL SURGERY	GENERAL SURGERY	02
48146	Pancreatectomy, distal, near-total with preservation of	66	02	GENERAL SURGERY	GENERAL SURGERY	02
48148	Excision of ampulla of Vater	49	02	GENERAL SURGERY	GENERAL SURGERY	02
48152	Pancreatectomy, proximal subtotal with total	66	02	GENERAL SURGERY	GENERAL SURGERY	02
48154	Pancreatectomy, proximal subtotal with near-total	27	02	GENERAL SURGERY	GENERAL SURGERY	02
48400	Injection procedure for intraoperative pancreatography	39	30	DIAGNOSTIC RADIOLOGY	GENERAL SURGERY	02
48500	Marsupialization of pancreatic cyst	10	02	GENERAL SURGERY	GENERAL SURGERY	02
48540	Internal anastomosis of pancreatic cyst to	82	02	GENERAL SURGERY	GENERAL SURGERY	02
48545	Pancreatorrhaphy for injury	45	02	GENERAL SURGERY	GENERAL SURGERY	02
48547	Duodenal exclusion with gastrojejunostomy for	55	02	GENERAL SURGERY	GENERAL SURGERY	02
48548	Pancreaticojejunostomy, side-to-side anastomosis	88	02	GENERAL SURGERY	GENERAL SURGERY	02
48552	Backbench reconstruction of cadaver donor pancreas	50	02	GENERAL SURGERY	GENERAL SURGERY	02
48556	Removal of transplanted pancreatic allograft	95	02	GENERAL SURGERY	GENERAL SURGERY	02
49220	Staging laparotomy for Hodgkins disease or lymphoma	20	02	GENERAL SURGERY	GENERAL SURGERY	02
49428	Ligation of peritoneal-venous shunt	29	02	GENERAL SURGERY	GENERAL SURGERY	02
49491	Repair, initial inguinal hernia, preterm infant (younger	2	02	GENERAL SURGERY	GENERAL SURGERY	02
49492	Repair, initial inguinal hernia, preterm infant (younger	3	02	GENERAL SURGERY	GENERAL SURGERY	02
49495	Repair, initial inguinal hernia, full term infant younger	4	02	GENERAL SURGERY	GENERAL SURGERY	02
49496	Repair, initial inguinal hernia, full term infant younger	1	02	GENERAL SURGERY	GENERAL SURGERY	02
49500	Repair initial inguinal hernia, age 6 months to younger	12	02	GENERAL SURGERY	GENERAL SURGERY	02
49501	Repair initial inguinal hernia, age 6 months to younger	20	02	GENERAL SURGERY	GENERAL SURGERY	02
49580	Repair umbilical hernia, younger than age 5 years;	8	02	GENERAL SURGERY	GENERAL SURGERY	02
49582	Repair umbilical hernia, younger than age 5 years;	22	02	GENERAL SURGERY	GENERAL SURGERY	02
49600	Repair of small omphalocele, with primary closure	34	02	GENERAL SURGERY	GENERAL SURGERY	02
49605	Repair of large omphalocele or gastroschisis; with or	11	02	GENERAL SURGERY	GENERAL SURGERY	02
49606	Repair of large omphalocele or gastroschisis; with	18	02	GENERAL SURGERY	GENERAL SURGERY	02
49610	Repair of omphalocele (Gross type operation); first	2	02	GENERAL SURGERY	GENERAL SURGERY	02
49611	Repair of omphalocele (Gross type operation); second	1	02	GENERAL SURGERY	GENERAL SURGERY	02
49906	Free omental flap with microvascular anastomosis	4	24	PLASTIC AND	GENERAL SURGERY	02
50045	Nephrotomy, with exploration	16	34	UROLOGY	UROLOGY	34

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50060	Nephrolithotomy; removal of calculus	60	34	UROLOGY	UROLOGY	34
50065	Nephrolithotomy; secondary surgical operation for	11	34	UROLOGY	UROLOGY	34
50070	Nephrolithotomy; complicated by congenital kidney	3	34	UROLOGY	UROLOGY	34
50075	Nephrolithotomy; removal of large staghorn calculus	45	34	UROLOGY	UROLOGY	34
50100	Transection or repositioning of aberrant renal vessels	10	77	VASCULAR SURGERY	GENERAL SURGERY	02
50120	Pyelotomy; with exploration	16	34	UROLOGY	UROLOGY	34
50125	Pyelotomy; with drainage, pyelostomy	5	34	UROLOGY	UROLOGY	34
50130	Pyelotomy; with removal of calculus (pyelolithotomy,	68	34	UROLOGY	UROLOGY	34
50135	Pyelotomy; complicated (eg, secondary operation,	15	34	UROLOGY	UROLOGY	34
50290	Excision of perinephric cyst	12	02	GENERAL SURGERY	UROLOGY	34
50340	Recipient nephrectomy (separate procedure)	68	02	GENERAL SURGERY	GENERAL SURGERY	02
50380	Renal autotransplantation, reimplantation of kidney	24	34	UROLOGY	GENERAL SURGERY	02
50405	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on	82	34	UROLOGY	UROLOGY	34
50500	Nephrorrhaphy, suture of kidney wound or injury	45	02	GENERAL SURGERY	GENERAL SURGERY	02
50520	Closure of nephrocutaneous or pyelocutaneous fistula	6	34	UROLOGY	UROLOGY	34
50525	Closure of nephrovisceral fistula (eg, renocolic),	6	34	UROLOGY	UROLOGY	34
50540	Symphysiotomy for horseshoe kidney with or without	4	34	UROLOGY	UROLOGY	34
50555	Renal endoscopy through established nephrostomy or	68	34	UROLOGY	UROLOGY	34
50557	Renal endoscopy through established nephrostomy or	62	34	UROLOGY	UROLOGY	34
50562	Renal endoscopy through established nephrostomy or	59	34	UROLOGY	UROLOGY	34
50570	Renal endoscopy through nephrotomy or pyelotomy,	46	34	UROLOGY	UROLOGY	34
50572	Renal endoscopy through nephrotomy or pyelotomy,	28	34	UROLOGY	UROLOGY	34
50574	Renal endoscopy through nephrotomy or pyelotomy,	18	34	UROLOGY	UROLOGY	34
50576	Renal endoscopy through nephrotomy or pyelotomy,	26	34	UROLOGY	UROLOGY	34
50580	Renal endoscopy through nephrotomy or pyelotomy,	62	34	UROLOGY	UROLOGY	34
50610	Ureterolithotomy; upper one-third of ureter	60	34	UROLOGY	UROLOGY	34
50620	Ureterolithotomy; middle one-third of ureter	33	34	UROLOGY	UROLOGY	34
50630	Ureterolithotomy; lower one-third of ureter	44	34	UROLOGY	UROLOGY	34
50660	Ureterectomy, total, ectopic ureter, combination	47	34	UROLOGY	UROLOGY	34
50686	Manometric studies through ureterostomy or indwelling	7	50	NURSE PRACTITIONERS	UROLOGY	34
50722	Ureterolysis for ovarian vein syndrome	36	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
50725	Ureterolysis for retrocaval ureter, with reanastomosis of	11	34	UROLOGY	UROLOGY	34
50728	Revision of urinary-cutaneous anastomosis (any type	64	34	UROLOGY	UROLOGY	34
50740	Ureteropyelostomy, anastomosis of ureter and renal pelvis	84	02	GENERAL SURGERY	GENERAL SURGERY	02
50750	Ureterocalycostomy, anastomosis of ureter to renal	1	34	UROLOGY	UROLOGY	34
50770	Transureteroureterostomy, anastomosis of ureter to	23	34	UROLOGY	UROLOGY	34
50782	Ureteroneocystostomy; anastomosis of duplicated	13	34	UROLOGY	UROLOGY	34
50783	Ureteroneocystostomy; with extensive ureteral tailoring	25	34	UROLOGY	UROLOGY	34
50810	Ureterosigmoidostomy, with creation of sigmoid	17	02	GENERAL SURGERY	GENERAL SURGERY	02

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50815	Ureterocolon conduit, including intestine anastomosis	60	34	UROLOGY	UROLOGY	34
50830	Urinary undiversion (eg, taking down of ureteroileal	48	34	UROLOGY	UROLOGY	34
50840	Replacement of all or part of ureter by intestine	28	34	UROLOGY	UROLOGY	34
50845	Cutaneous appendico-vesicostomy	91	34	UROLOGY	UROLOGY	34
50860	Ureterostomy, transplantation of ureter to skin	55	34	UROLOGY	UROLOGY	34
50900	Ureterorrhaphy, suture of ureter (separate procedure)	92	34	UROLOGY	UROLOGY	34
50920	Closure of ureterocutaneous fistula	12	34	UROLOGY	UROLOGY	34
50930	Closure of ureterovisceral fistula (including visceral	11	34	UROLOGY	UROLOGY	34
50940	Deligation of ureter	11	34	UROLOGY	UROLOGY	34
50945	Laparoscopy, surgical; ureterolithotomy	10	34	UROLOGY	UROLOGY	34
50947	Laparoscopy, surgical; ureteroneocystostomy with	31	34	UROLOGY	UROLOGY	34
50948	Laparoscopy, surgical; ureteroneocystostomy without	5	34	UROLOGY	UROLOGY	34
50949	Unlisted laparoscopy procedure, ureter	43	34	UROLOGY	UROLOGY	34
50955	Ureteral endoscopy through established ureterostomy,	36	34	UROLOGY	UROLOGY	34
50957	Ureteral endoscopy through established ureterostomy,	30	34	UROLOGY	UROLOGY	34
50970	Ureteral endoscopy through ureterotomy, with or	32	34	UROLOGY	UROLOGY	34
50972	Ureteral endoscopy through ureterotomy, with or	18	34	UROLOGY	UROLOGY	34
50974	Ureteral endoscopy through ureterotomy, with or	7	34	UROLOGY	UROLOGY	34
50976	Ureteral endoscopy through ureterotomy, with or	11	34	UROLOGY	UROLOGY	34
50980	Ureteral endoscopy through ureterotomy, with or	23	34	UROLOGY	UROLOGY	34
51030	Cystotomy or cystostomy; with cryosurgical destruction	19	34	UROLOGY	UROLOGY	34
51060	Transvesical ureterolithotomy	25	34	UROLOGY	UROLOGY	34
51080	Drainage of perivesical or prevesical space abscess	59	34	UROLOGY	UROLOGY	34
51500	Excision of urachal cyst or sinus, with or without	58	34	UROLOGY	UROLOGY	34
51520	Cystotomy; for simple excision of vesical neck	41	34	UROLOGY	UROLOGY	34
51535	Cystotomy for excision, incision, or repair of	74	34	UROLOGY	UROLOGY	34
51565	Cystectomy, partial, with reimplantation of ureter(s) into	93	34	UROLOGY	UROLOGY	34
51580	Cystectomy, complete, with ureterosigmoidostomy or	18	34	UROLOGY	UROLOGY	34
51585	Cystectomy, complete, with ureterosigmoidostomy or	68	34	UROLOGY	UROLOGY	34
51820	Cystourethroplasty with unilateral or bilateral	6	34	UROLOGY	UROLOGY	34
51920	Closure of vesicouterine fistula;	3	34	UROLOGY	UROLOGY	34
51925	Closure of vesicouterine fistula; with hysterectomy	2	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
51940	Closure, exstrophy of bladder	4	34	UROLOGY	UROLOGY	34
51980	Cutaneous vesicostomy	34	34	UROLOGY	UROLOGY	34
52010	Cystourethroscopy, with ejaculatory duct	39	34	UROLOGY	UROLOGY	34
52301	Cystourethroscopy; with resection or fulguration of	51	34	UROLOGY	UROLOGY	34
52343	Cystourethroscopy; with treatment of intra-renal	33	34	UROLOGY	UROLOGY	34
52402	Cystourethroscopy with transurethral resection or	38	34	UROLOGY	UROLOGY	34
52700	Transurethral drainage of prostatic abscess	82	34	UROLOGY	UROLOGY	34
53000	Urethrotomy or urethrostomy, external (separate	96	34	UROLOGY	UROLOGY	34

RUC Recommended Dominant Specialty for PLI Methodology

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53040	Drainage of deep periurethral abscess	78	34	UROLOGY	UROLOGY	34
53060	Drainage of Skene's gland abscess or cyst	23	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
53080	Drainage of perineal urinary extravasation;	10	34	UROLOGY	UROLOGY	34
53085	Drainage of perineal urinary extravasation; complicated	30	01	GENERAL PRACTICE	UROLOGY	34
53210	Urethrectomy, total, including cystostomy; female	92	34	UROLOGY	UROLOGY	34
53235	Excision of urethral diverticulum (separate procedure);	29	34	UROLOGY	UROLOGY	34
53240	Marsupialization of urethral diverticulum, male or	11	34	UROLOGY	UROLOGY	34
53250	Excision of bulbourethral gland (Cowper's gland)	1	34	UROLOGY	UROLOGY	34
53270	Excision or fulguration; Skene's glands	22	34	UROLOGY	UROLOGY	34
53405	Urethroplasty; second stage (formation of urethra),	19	34	UROLOGY	UROLOGY	34
53420	Urethroplasty, 2-stage reconstruction or repair of	10	34	UROLOGY	UROLOGY	34
53425	Urethroplasty, 2-stage reconstruction or repair of	5	34	UROLOGY	UROLOGY	34
53431	Urethroplasty with tubularization of posterior urethra	27	34	UROLOGY	UROLOGY	34
53448	Removal and replacement of inflatable urethral/bladder	45	34	UROLOGY	UROLOGY	34
53460	Urethromeatoplasty, with partial excision of distal	53	34	UROLOGY	UROLOGY	34
53502	Urethrorrhaphy, suture of urethral wound or injury,	55	34	UROLOGY	UROLOGY	34
53505	Urethrorrhaphy, suture of urethral wound or injury;	58	34	UROLOGY	UROLOGY	34
53510	Urethrorrhaphy, suture of urethral wound or injury;	44	34	UROLOGY	UROLOGY	34
53515	Urethrorrhaphy, suture of urethral wound or injury;	22	34	UROLOGY	UROLOGY	34
53520	Closure of urethrostomy or urethrocutaneous fistula,	31	34	UROLOGY	UROLOGY	34
54000	Slitting of prepuce, dorsal or lateral (separate	38	34	UROLOGY	UROLOGY	34
54110	Excision of penile plaque (Peyronie disease);	41	34	UROLOGY	UROLOGY	34
54111	Excision of penile plaque (Peyronie disease); with graft	44	34	UROLOGY	UROLOGY	34
54112	Excision of penile plaque (Peyronie disease); with graft	45	34	UROLOGY	UROLOGY	34
54115	Removal foreign body from deep penile tissue (eg,	50	34	UROLOGY	UROLOGY	34
54130	Amputation of penis, radical; with bilateral	11	34	UROLOGY	UROLOGY	34
54135	Amputation of penis, radical; in continuity with bilateral	1	34	UROLOGY	UROLOGY	34
54160	Circumcision, surgical excision other than clamp,	17	34	UROLOGY	UROLOGY	34
54205	Injection procedure for Peyronie disease; with surgical	9	34	UROLOGY	UROLOGY	34
54304	Plastic operation on penis for correction of chordee or	14	34	UROLOGY	UROLOGY	34
54308	Urethroplasty for second stage hypospadias repair	1	34	UROLOGY	UROLOGY	34
54312	Urethroplasty for second stage hypospadias repair	2	34	UROLOGY	UROLOGY	34
54316	Urethroplasty for second stage hypospadias repair	1	34	UROLOGY	UROLOGY	34
54318	Urethroplasty for third stage hypospadias repair to	2	34	UROLOGY	UROLOGY	34
54322	One stage distal hypospadias repair (with or without	13	34	UROLOGY	UROLOGY	34
54324	One stage distal hypospadias repair (with or without	7	34	UROLOGY	UROLOGY	34
54326	One stage distal hypospadias repair (with or without	2	34	UROLOGY	UROLOGY	34
54328	One stage distal hypospadias repair (with or without	3	34	UROLOGY	UROLOGY	34
54332	One stage proximal penile or penoscrotal hypospadias	3	34	UROLOGY	UROLOGY	34
54340	Repair of hypospadias complications (ie, fistula,	10	34	UROLOGY	UROLOGY	34

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54344	Repair of hypospadias complications (ie, fistula,	3	34	UROLOGY	UROLOGY	34
54348	Repair of hypospadias complications (ie, fistula,	5	34	UROLOGY	UROLOGY	34
54352	Repair of hypospadias cripple requiring extensive	4	34	UROLOGY	UROLOGY	34
54380	Plastic operation on penis for epispadias distal to	1	34	UROLOGY	UROLOGY	34
54385	Plastic operation on penis for epispadias distal to	1	10	GASTROENTEROLOGY	UROLOGY	34
54417	Removal and replacement of non-inflatable (semi-rigid)	30	34	UROLOGY	UROLOGY	34
54420	Corpora cavernosa-saphenous vein shunt (priapism	16	34	UROLOGY	UROLOGY	34
54430	Corpora cavernosa-corpus spongiosum shunt	56	34	UROLOGY	UROLOGY	34
54435	Corpora cavernosa-glans penis fistulization (eg, biopsy	61	34	UROLOGY	UROLOGY	34
54440	Plastic operation of penis for injury	82	34	UROLOGY	UROLOGY	34
54500	Biopsy of testis, needle (separate procedure)	23	34	UROLOGY	UROLOGY	34
54522	Orchiectomy, partial	82	34	UROLOGY	UROLOGY	34
54535	Orchiectomy, radical, for tumor; with abdominal	28	34	UROLOGY	UROLOGY	34
54550	Exploration for undescended testis (inguinal or scrotal	51	34	UROLOGY	UROLOGY	34
54560	Exploration for undescended testis with abdominal	6	34	UROLOGY	UROLOGY	34
54600	Reduction of torsion of testis, surgical, with or without	39	34	UROLOGY	UROLOGY	34
54620	Fixation of contralateral testis (separate procedure)	24	34	UROLOGY	UROLOGY	34
54650	Orchiopexy, abdominal approach, for intra-abdominal	11	34	UROLOGY	UROLOGY	34
54660	Insertion of testicular prosthesis (separate procedure)	15	34	UROLOGY	UROLOGY	34
54670	Suture or repair of testicular injury	12	34	UROLOGY	UROLOGY	34
54680	Transplantation of testis(es) to thigh (because of	32	34	UROLOGY	UROLOGY	34
54690	Laparoscopy, surgical; orchiectomy	22	02	GENERAL SURGERY	UROLOGY	34
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal	2	34	UROLOGY	UROLOGY	34
54699	Unlisted laparoscopy procedure, testis	5	34	UROLOGY	UROLOGY	34
54800	Biopsy of epididymis, needle	10	07	DERMATOLOGY	UROLOGY	34
54861	Epididymectomy; bilateral	71	34	UROLOGY	UROLOGY	34
54865	Exploration of epididymis, with or without biopsy	28	34	UROLOGY	UROLOGY	34
54901	Epididymovasostomy, anastomosis of epididymis to	3	34	UROLOGY	UROLOGY	34
55200	Vasotomy, cannulization with or without incision of vas,	9	34	UROLOGY	UROLOGY	34
55300	Vasotomy for vasograms, seminal vesiculograms, or	3	34	UROLOGY	UROLOGY	34
55400	Vasovasostomy, vasovasorrhaphy	14	34	UROLOGY	UROLOGY	34
55450	Ligation (percutaneous) of vas deferens, unilateral or	9	34	UROLOGY	UROLOGY	34
55535	Excision of varicocele or ligation of spermatic veins for	32	34	UROLOGY	UROLOGY	34
55550	Laparoscopy, surgical, with ligation of spermatic veins	16	34	UROLOGY	UROLOGY	34
55600	Vesiculotomy;	91	34	UROLOGY	UROLOGY	34
55605	Vesiculotomy; complicated	2	16	OBSTETRICS/GYNECOLOGY	UROLOGY	34
55650	Vesiculectomy, any approach	64	34	UROLOGY	UROLOGY	34
55680	Excision of Mullerian duct cyst	1	34	UROLOGY	UROLOGY	34
55706	Biopsies, prostate, needle, transperineal, stereotactic	93	34	UROLOGY	UROLOGY	34
55720	Prostatotomy, external drainage of prostatic abscess,	34	34	UROLOGY	UROLOGY	34

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55725	Prostatotomy, external drainage of prostatic abscess,	14	34	UROLOGY	UROLOGY	34
55801	Prostatectomy, perineal, subtotal (including control of	14	34	UROLOGY	UROLOGY	34
55812	Prostatectomy, perineal radical; with lymph node	10	34	UROLOGY	UROLOGY	34
55815	Prostatectomy, perineal radical; with bilateral pelvic	64	34	UROLOGY	UROLOGY	34
55862	Exposure of prostate, any approach, for insertion of	5	34	UROLOGY	UROLOGY	34
55865	Exposure of prostate, any approach, for insertion of	9	34	UROLOGY	UROLOGY	34
55870	Electroejaculation	26	34	UROLOGY	UROLOGY	34
56442	Hymenotomy, simple incision	28	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
56634	Vulvectomy, radical, complete; with unilateral	63	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	98
56640	Vulvectomy, radical, complete, with inguinofemoral,	25	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	98
56700	Partial hymenectomy or revision of hymenal ring	52	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
56805	Clitoroplasty for intersex state	1	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57000	Colpotomy; with exploration	83	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57020	Colpocentesis (separate procedure)	82	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
57022	Incision and drainage of vaginal hematoma;	7	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57023	Incision and drainage of vaginal hematoma; non-	82	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57109	Vaginectomy, partial removal of vaginal wall; with	28	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	16
57111	Vaginectomy, complete removal of vaginal wall; with	41	16	OBSTETRICS/GYNECOLOGY	GYNECOLOGY/ONCOLOGY	16
57112	Vaginectomy, complete removal of vaginal wall; with	6	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	98
57130	Excision of vaginal septum	72	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57170	Diaphragm or cervical cap fitting with instructions	92	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
57230	Plastic repair of urethrocele	59	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57289	Pereyra procedure, including anterior colporrhaphy	68	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
57291	Construction of artificial vagina; without graft	12	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57292	Construction of artificial vagina; with graft	50	98	GYNECOLOGY/ONCOLOGY	OB-GYN	16
57296	Revision (including removal) of prosthetic vaginal graft;	36	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
57307	Closure of rectovaginal fistula; abdominal approach,	29	02	GENERAL SURGERY	GENERAL SURGERY	02
57308	Closure of rectovaginal fistula; transperineal approach,	63	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57310	Closure of urethrovaginal fistula;	50	34	UROLOGY	UROLOGY	34
57311	Closure of urethrovaginal fistula; with bulbocavernosus	15	34	UROLOGY	UROLOGY	34
57320	Closure of vesicovaginal fistula; vaginal approach	93	34	UROLOGY	UROLOGY	34
57330	Closure of vesicovaginal fistula; transvesical and	27	34	UROLOGY	UROLOGY	34
57335	Vaginoplasty for intersex state	10	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57531	Radical trachelectomy, with bilateral total pelvic	10	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57540	Excision of cervical stump, abdominal approach;	18	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57545	Excision of cervical stump, abdominal approach; with	4	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57550	Excision of cervical stump, vaginal approach;	30	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57555	Excision of cervical stump, vaginal approach; with	24	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
57558	Dilation and curettage of cervical stump	74	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
57700	Cerclage of uterine cervix, nonobstetrical	15	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16

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57720	Trachelorrhaphy, plastic repair of uterine cervix, vaginal	30	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58146	Myomectomy, excision of fibroid tumor(s) of uterus, 5	66	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58285	Vaginal hysterectomy, radical (Schauta type operation)	19	98	GYNECOLOGY/ONCOLOGY	GYNECOLOGY/ONCOLOGY	98
58291	Vaginal hysterectomy, for uterus greater than 250 g;	89	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58292	Vaginal hysterectomy, for uterus greater than 250 g;	46	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58293	Vaginal hysterectomy, for uterus greater than 250 g;	16	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58294	Vaginal hysterectomy, for uterus greater than 250 g;	35	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58321	Artificial insemination; intra-cervical	1	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58322	Artificial insemination; intra-uterine	58	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58323	Sperm washing for artificial insemination	23	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58345	Transcervical introduction of fallopian tube catheter for	12	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58346	Insertion of Heyman capsules for clinical brachytherapy	34	92	RADIATION ONCOLOGY	GYNECOLOGY/ONCOLOGY	98
58410	Uterine suspension, with or without shortening of round	5	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58520	Hysterorrhaphy, repair of ruptured uterus	16	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58540	Hysteroplasty, repair of uterine anomaly (Strassman	1	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58543	Laparoscopy, surgical, supracervical hysterectomy, for	62	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
58544	Laparoscopy, surgical, supracervical hysterectomy, for	66	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
58546	Laparoscopy, surgical, myomectomy, excision; 5 or	10	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58553	Laparoscopy, surgical, with vaginal hysterectomy, for	96	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58560	Hysteroscopy, surgical; with division or resection of	60	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58562	Hysteroscopy, surgical; with removal of impacted	70	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58579	Unlisted hysteroscopy procedure, uterus	11	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58600	Ligation or transection of fallopian tube(s), abdominal	31	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58605	Ligation or transection of fallopian tube(s), abdominal	59	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58615	Occlusion of fallopian tube(s) by device (eg, band, clip,	4	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58672	Laparoscopy, surgical; with fimbrioplasty	10	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58673	Laparoscopy, surgical; with salpingostomy	35	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58679	Unlisted laparoscopy procedure, oviduct, ovary	18	02	GENERAL SURGERY	OB-GYN	16
58750	Tubotubal anastomosis	5	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58752	Tubouterine implantation	2	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58760	Fimbrioplasty	4	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58770	Salpingostomy (salpingoneostomy)	6	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58800	Drainage of ovarian cyst(s), unilateral or bilateral	44	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58805	Drainage of ovarian cyst(s), unilateral or bilateral	84	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
58820	Drainage of ovarian abscess; vaginal approach, open	9	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58822	Drainage of ovarian abscess; abdominal approach	22	02	GENERAL SURGERY	OB-GYN	16
58825	Transposition, ovary(s)	9	98	GYNECOLOGY/ONCOLOGY	OB-GYN	16
58900	Biopsy of ovary, unilateral or bilateral (separate	56	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58920	Wedge resection or bisection of ovary, unilateral or	30	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
58970	Follicle puncture for oocyte retrieval, any method	4	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16

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58974	Embryo transfer, intrauterine	2	46	ENDOCRINOLOGY	OB-GYN	16
59001	Amniocentesis; therapeutic amniotic fluid reduction	10	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59012	Cordocentesis (intrauterine), any method	1	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59015	Chorionic villus sampling, any method	42	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59030	Fetal scalp blood sampling	1	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59050	Fetal monitoring during labor by consulting physician	11	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59051	Fetal monitoring during labor by consulting physician	73	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
59070	Transabdominal amnioinfusion, including ultrasound	2	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59074	Fetal fluid drainage (eg, vesicocentesis,	3	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59076	Fetal shunt placement, including ultrasound guidance	1	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59100	Hysterotomy, abdominal (eg, for hydatidiform mole,	9	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59120	Surgical treatment of ectopic pregnancy; tubal or	67	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59121	Surgical treatment of ectopic pregnancy; tubal or	9	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59136	Surgical treatment of ectopic pregnancy; interstitial,	1	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59150	Laparoscopic treatment of ectopic pregnancy; without	25	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59151	Laparoscopic treatment of ectopic pregnancy; with	95	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59160	Curettage, postpartum	88	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59300	Episiotomy or vaginal repair, by other than attending	26	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59325	Cerclage of cervix, during pregnancy; abdominal	2	02	GENERAL SURGERY	OB-GYN	16
59350	Hysterorrhaphy of ruptured uterus	3	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59412	External cephalic version, with or without tocolysis	25	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59414	Delivery of placenta (separate procedure)	33	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59525	Subtotal or total hysterectomy after cesarean delivery	12	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59610	Routine obstetric care including antepartum care,	55	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59612	Vaginal delivery only, after previous cesarean delivery	44	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59614	Vaginal delivery only, after previous cesarean delivery	31	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59618	Routine obstetric care including antepartum care,	14	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59620	Cesarean delivery only, following attempted vaginal	6	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59622	Cesarean delivery only, following attempted vaginal	5	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59821	Treatment of missed abortion, completed surgically;	49	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59830	Treatment of septic abortion, completed surgically	5	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59840	Induced abortion, by dilation and curettage	82	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59841	Induced abortion, by dilation and evacuation	45	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59851	Induced abortion, by one or more intra-amniotic	3	98	GYNECOLOGY/ONCOLOGY	OB-GYN	16
59855	Induced abortion, by one or more vaginal suppositories	7	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59856	Induced abortion, by one or more vaginal suppositories	10	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59866	Multifetal pregnancy reduction(s) (MPR)	1	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59870	Uterine evacuation and curettage for hydatidiform mole	9	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
59871	Removal of cerclage suture under anesthesia (other	28	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
60000	Incision and drainage of thyroglossal duct cyst, infected	13	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04

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60281	Excision of thyroglossal duct cyst or sinus; recurrent	13	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
60605	Excision of carotid body tumor; with excision of carotid	15	77	VASCULAR SURGERY	VASCULAR SURGERY	77
61000	Subdural tap through fontanelle, or suture, infant,	7	11	INTERNAL MEDICINE	NEUROSURGERY	14
61001	Subdural tap through fontanelle, or suture, infant,	7	05	ANESTHESIOLOGY	NEUROSURGERY	14
61151	Burr hole(s) or trephine; with subsequent tapping	17	14	NEUROSURGERY	NEUROSURGERY	14
61156	Burr hole(s); with aspiration of hematoma or cyst,	89	14	NEUROSURGERY	NEUROSURGERY	14
61250	Burr hole(s) or trephine, supratentorial, exploratory, not	39	14	NEUROSURGERY	NEUROSURGERY	14
61253	Burr hole(s) or trephine, infratentorial, unilateral or	18	14	NEUROSURGERY	NEUROSURGERY	14
61305	Craniectomy or craniotomy, exploratory; infratentorial	36	14	NEUROSURGERY	NEUROSURGERY	14
61321	Craniectomy or craniotomy, drainage of intracranial	21	14	NEUROSURGERY	NEUROSURGERY	14
61330	Decompression of orbit only, transcranial approach	22	04	OTOLARYNGOLOGY	NEUROSURGERY	14
61332	Exploration of orbit (transcranial approach); with biopsy	17	18	OPHTHALMOLOGY	NEUROSURGERY	14
61333	Exploration of orbit (transcranial approach); with	29	14	NEUROSURGERY	NEUROSURGERY	14
61334	Exploration of orbit (transcranial approach); with	5	18	OPHTHALMOLOGY	NEUROSURGERY	14
61340	Subtemporal cranial decompression (pseudotumor	35	14	NEUROSURGERY	NEUROSURGERY	14
61345	Other cranial decompression, posterior fossa	54	14	NEUROSURGERY	NEUROSURGERY	14
61440	Craniotomy for section of tentorium cerebelli (separate	1	14	NEUROSURGERY	NEUROSURGERY	14
61450	Craniectomy, subtemporal, for section, compression, or	25	14	NEUROSURGERY	NEUROSURGERY	14
61460	Craniectomy, suboccipital; for section of one or more	32	14	NEUROSURGERY	NEUROSURGERY	14
61470	Craniectomy, suboccipital; for medullary tractotomy	3	14	NEUROSURGERY	NEUROSURGERY	14
61490	Craniotomy for lobotomy, including cingulotomy	6	14	NEUROSURGERY	NEUROSURGERY	14
61516	Craniectomy, trephination, bone flap craniotomy; for	93	14	NEUROSURGERY	NEUROSURGERY	14
61521	Craniectomy for excision of brain tumor, infratentorial	63	14	NEUROSURGERY	NEUROSURGERY	14
61522	Craniectomy, infratentorial or posterior fossa; for	31	14	NEUROSURGERY	NEUROSURGERY	14
61524	Craniectomy, infratentorial or posterior fossa; for	62	14	NEUROSURGERY	NEUROSURGERY	14
61526	Craniectomy, bone flap craniotomy, transtemporal	56	04	OTOLARYNGOLOGY	NEUROSURGERY	14
61530	Craniectomy, bone flap craniotomy, transtemporal	17	14	NEUROSURGERY	NEUROSURGERY	14
61531	Subdural implantation of strip electrodes through one	39	14	NEUROSURGERY	NEUROSURGERY	14
61534	Craniotomy with elevation of bone flap; for excision of	22	14	NEUROSURGERY	NEUROSURGERY	14
61535	Craniotomy with elevation of bone flap; for removal of	51	14	NEUROSURGERY	NEUROSURGERY	14
61536	Craniotomy with elevation of bone flap; for excision of	47	14	NEUROSURGERY	NEUROSURGERY	14
61538	Craniotomy with elevation of bone flap; for lobectomy,	75	14	NEUROSURGERY	NEUROSURGERY	14
61539	Craniotomy with elevation of bone flap; for lobectomy,	12	14	NEUROSURGERY	NEUROSURGERY	14
61540	Craniotomy with elevation of bone flap; for lobectomy,	32	14	NEUROSURGERY	NEUROSURGERY	14
61541	Craniotomy with elevation of bone flap; for transection	17	14	NEUROSURGERY	NEUROSURGERY	14
61542	Craniotomy with elevation of bone flap; for total	1	14	NEUROSURGERY	NEUROSURGERY	14
61543	Craniotomy with elevation of bone flap; for partial or	7	14	NEUROSURGERY	NEUROSURGERY	14
61545	Craniotomy with elevation of bone flap; for excision of	40	14	NEUROSURGERY	NEUROSURGERY	14
61546	Craniotomy for hypophysectomy or excision of pituitary	59	14	NEUROSURGERY	NEUROSURGERY	14
61550	Craniectomy for craniosynostosis; single cranial suture	3	24	PLASTIC AND	NEUROSURGERY	14

RUC Recommended Dominant Specialty for PLI Methodology

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61552	Craniectomy for craniosynostosis; multiple cranial	1	14	NEUROSURGERY	NEUROSURGERY	14
61556	Craniotomy for craniosynostosis; frontal or parietal	8	14	NEUROSURGERY	NEUROSURGERY	14
61557	Craniotomy for craniosynostosis; bifrontal bone flap	4	14	NEUROSURGERY	NEUROSURGERY	14
61558	Extensive craniectomy for multiple cranial suture	1	14	NEUROSURGERY	NEUROSURGERY	14
61559	Extensive craniectomy for multiple cranial suture	1	14	NEUROSURGERY	NEUROSURGERY	14
61563	Excision, intra and extracranial, benign tumor of cranial	18	14	NEUROSURGERY	NEUROSURGERY	14
61564	Excision, intra and extracranial, benign tumor of cranial	11	14	NEUROSURGERY	NEUROSURGERY	14
61566	Craniotomy with elevation of bone flap; for selective	30	14	NEUROSURGERY	NEUROSURGERY	14
61567	Craniotomy with elevation of bone flap; for multiple	6	14	NEUROSURGERY	NEUROSURGERY	14
61570	Craniectomy or craniotomy; with excision of foreign	19	14	NEUROSURGERY	NEUROSURGERY	14
61571	Craniectomy or craniotomy; with treatment of	25	14	NEUROSURGERY	NEUROSURGERY	14
61575	Transoral approach to skull base, brain stem or upper	59	14	NEUROSURGERY	NEUROSURGERY	14
61576	Transoral approach to skull base, brain stem or upper	4	14	NEUROSURGERY	NEUROSURGERY	14
61581	Craniofacial approach to anterior cranial fossa;	45	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
61582	Craniofacial approach to anterior cranial fossa;	51	14	NEUROSURGERY	NEUROSURGERY	14
61585	Orbitocranial approach to anterior cranial fossa,	17	14	NEUROSURGERY	NEUROSURGERY	14
61586	Bicoronal, transzygomatic and/or LeFort I osteotomy	28	14	NEUROSURGERY	NEUROSURGERY	14
61596	Transcochlear approach to posterior cranial fossa,	49	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
61597	Transcondylar (far lateral) approach to posterior cranial	89	14	NEUROSURGERY	NEUROSURGERY	14
61598	Transpetrosal approach to posterior cranial fossa,	35	04	OTOLARYNGOLOGY	NEUROSURGERY	14
61607	Resection or excision of neoplastic, vascular or	62	14	NEUROSURGERY	NEUROSURGERY	14
61610	Transection or ligation, carotid artery in cavernous	1	14	NEUROSURGERY	NEUROSURGERY	14
61611	Transection or ligation, carotid artery in petrous canal;	0	14	NEUROSURGERY	NEUROSURGERY	14
61613	Obliteration of carotid aneurysm, arteriovenous	10	14	NEUROSURGERY	NEUROSURGERY	14
61615	Resection or excision of neoplastic, vascular or	69	04	OTOLARYNGOLOGY	NEUROSURGERY	14
61635	Transcatheter placement of intravascular stent(s),	1	14	NEUROSURGERY	NEUROSURGERY	14
61680	Surgery of intracranial arteriovenous malformation;	85	14	NEUROSURGERY	NEUROSURGERY	14
61682	Surgery of intracranial arteriovenous malformation;	86	14	NEUROSURGERY	NEUROSURGERY	14
61684	Surgery of intracranial arteriovenous malformation;	22	14	NEUROSURGERY	NEUROSURGERY	14
61686	Surgery of intracranial arteriovenous malformation;	37	14	NEUROSURGERY	NEUROSURGERY	14
61690	Surgery of intracranial arteriovenous malformation;	13	14	NEUROSURGERY	NEUROSURGERY	14
61692	Surgery of intracranial arteriovenous malformation;	18	14	NEUROSURGERY	NEUROSURGERY	14
61698	Surgery of complex intracranial aneurysm, intracranial	55	14	NEUROSURGERY	NEUROSURGERY	14
61702	Surgery of simple intracranial aneurysm, intracranial	35	14	NEUROSURGERY	NEUROSURGERY	14
61703	Surgery of intracranial aneurysm, cervical approach by	6	14	NEUROSURGERY	NEUROSURGERY	14
61705	Surgery of aneurysm, vascular malformation or carotid-	8	14	NEUROSURGERY	NEUROSURGERY	14
61708	Surgery of aneurysm, vascular malformation or carotid-	34	92	RADIATION ONCOLOGY	NEUROSURGERY	14
61711	Anastomosis, arterial, extracranial-intracranial (eg,	93	14	NEUROSURGERY	NEUROSURGERY	14
61720	Creation of lesion by stereotactic method, including	85	13	NEUROLOGY	NEUROSURGERY	14
61735	Creation of lesion by stereotactic method, including	13	13	NEUROLOGY	NEUROSURGERY	13

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61760	Stereotactic implantation of depth electrodes into the	93	14	NEUROSURGERY	NEUROSURGERY	14
61791	Creation of lesion by stereotactic method,	94	14	NEUROSURGERY	NEUROSURGERY	14
61850	Twist drill or burr hole(s) for implantation of	2	14	NEUROSURGERY	NEUROSURGERY	14
61860	Craniectomy or craniotomy for implantation of	27	14	NEUROSURGERY	NEUROSURGERY	14
61864	Twist drill, burr hole, craniotomy, or craniectomy with	81	14	NEUROSURGERY	NEUROSURGERY	14
61870	Craniectomy for implantation of neurostimulator	3	14	NEUROSURGERY	NEUROSURGERY	14
61875	Craniectomy for implantation of neurostimulator	1	14	NEUROSURGERY	NEUROSURGERY	14
62000	Elevation of depressed skull fracture; simple, extradural	18	14	NEUROSURGERY	NEUROSURGERY	14
62005	Elevation of depressed skull fracture; compound or	26	14	NEUROSURGERY	NEUROSURGERY	14
62010	Elevation of depressed skull fracture; with repair of	91	14	NEUROSURGERY	NEUROSURGERY	14
62115	Reduction of craniomegalic skull (eg, treated	1	05	ANESTHESIOLOGY	NEUROSURGERY	14
62116	Reduction of craniomegalic skull (eg, treated	3	14	NEUROSURGERY	NEUROSURGERY	14
62117	Reduction of craniomegalic skull (eg, treated	1	14	NEUROSURGERY	NEUROSURGERY	04
62120	Repair of encephalocele, skull vault, including	43	04	OTOLARYNGOLOGY	NEUROSURGERY	14
62121	Craniotomy for repair of encephalocele, skull base	25	04	OTOLARYNGOLOGY	NEUROSURGERY	14
62145	Cranioplasty for skull defect with reparative brain	84	14	NEUROSURGERY	NEUROSURGERY	14
62146	Cranioplasty with autograft (includes obtaining bone	49	14	NEUROSURGERY	NEUROSURGERY	14
62147	Cranioplasty with autograft (includes obtaining bone	58	14	NEUROSURGERY	NEUROSURGERY	14
62148	Incision and retrieval of subcutaneous cranial bone	50	14	NEUROSURGERY	NEUROSURGERY	14
62161	Neuroendoscopy, intracranial; with dissection of	70	14	NEUROSURGERY	NEUROSURGERY	14
62162	Neuroendoscopy, intracranial; with fenestration or	22	14	NEUROSURGERY	NEUROSURGERY	14
62163	Neuroendoscopy, intracranial; with retrieval of foreign	5	14	NEUROSURGERY	NEUROSURGERY	14
62164	Neuroendoscopy, intracranial; with excision of brain	40	14	NEUROSURGERY	NEUROSURGERY	14
62180	Ventriculocisternostomy (Torkildsen type operation)	39	14	NEUROSURGERY	NEUROSURGERY	14
62190	Creation of shunt; subarachnoid/subdural-atrial, -	21	14	NEUROSURGERY	NEUROSURGERY	14
62194	Replacement or irrigation, subarachnoid/subdural	58	14	NEUROSURGERY	NEUROSURGERY	14
62200	Ventriculocisternostomy, third ventricle;	50	14	NEUROSURGERY	NEUROSURGERY	14
62201	Ventriculocisternostomy, third ventricle; stereotactic,	96	14	NEUROSURGERY	NEUROSURGERY	14
62294	Injection procedure, arterial, for occlusion of	4	30	DIAGNOSTIC RADIOLOGY	NEUROSURGERY	14
63050	Laminoplasty, cervical, with decompression of the	91	14	NEUROSURGERY	NEUROSURGERY	14
63066	Costovertebral approach with decompression of spinal	55	14	NEUROSURGERY	NEUROSURGERY	14
63170	Laminectomy with myelotomy (eg, Bischof or DREZ	15	14	NEUROSURGERY	NEUROSURGERY	14
63173	Laminectomy with drainage of intramedullary	27	14	NEUROSURGERY	NEUROSURGERY	14
63180	Laminectomy and section of dentate ligaments, with or	2	13	NEUROLOGY	NEUROSURGERY	14
63185	Laminectomy with rhizotomy; 1 or 2 segments	56	14	NEUROSURGERY	NEUROSURGERY	14
63190	Laminectomy with rhizotomy; more than 2 segments	37	14	NEUROSURGERY	NEUROSURGERY	14
63191	Laminectomy with section of spinal accessory nerve	3	05	ANESTHESIOLOGY	NEUROSURGERY	14
63194	Laminectomy with cordotomy, with section of 1	3	14	NEUROSURGERY	NEUROSURGERY	14
63195	Laminectomy with cordotomy, with section of 1	4	14	NEUROSURGERY	NEUROSURGERY	14
63196	Laminectomy with cordotomy, with section of both	1	14	NEUROSURGERY	NEUROSURGERY	14

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63197	Laminectomy with cordotomy, with section of both	1	14	NEUROSURGERY	NEUROSURGERY	14
63199	Laminectomy with cordotomy with section of both	1	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14
63250	Laminectomy for excision or occlusion of arteriovenous	12	14	NEUROSURGERY	NEUROSURGERY	14
63251	Laminectomy for excision or occlusion of arteriovenous	38	14	NEUROSURGERY	NEUROSURGERY	14
63252	Laminectomy for excision or occlusion of arteriovenous	33	14	NEUROSURGERY	NEUROSURGERY	14
63268	Laminectomy for excision or evacuation of intraspinal	44	14	NEUROSURGERY	NEUROSURGERY	14
63270	Laminectomy for excision of intraspinal lesion other	56	14	NEUROSURGERY	NEUROSURGERY	14
63273	Laminectomy for excision of intraspinal lesion other	20	14	NEUROSURGERY	NEUROSURGERY	14
63278	Laminectomy for biopsy/excision of intraspinal	58	14	NEUROSURGERY	NEUROSURGERY	14
63283	Laminectomy for biopsy/excision of intraspinal	16	14	NEUROSURGERY	NEUROSURGERY	14
63285	Laminectomy for biopsy/excision of intraspinal	62	14	NEUROSURGERY	NEUROSURGERY	14
63286	Laminectomy for biopsy/excision of intraspinal	75	14	NEUROSURGERY	NEUROSURGERY	14
63287	Laminectomy for biopsy/excision of intraspinal	46	14	NEUROSURGERY	NEUROSURGERY	14
63290	Laminectomy for biopsy/excision of intraspinal	36	14	NEUROSURGERY	NEUROSURGERY	14
63295	Osteoplastic reconstruction of dorsal spinal elements,	28	14	NEUROSURGERY	NEUROSURGERY	14
63301	Vertebral corpectomy (vertebral body resection), partial	72	14	NEUROSURGERY	NEUROSURGERY	14
63302	Vertebral corpectomy (vertebral body resection), partial	25	14	NEUROSURGERY	NEUROSURGERY	14
63303	Vertebral corpectomy (vertebral body resection), partial	61	14	NEUROSURGERY	NEUROSURGERY	14
63304	Vertebral corpectomy (vertebral body resection), partial	8	14	NEUROSURGERY	NEUROSURGERY	14
63305	Vertebral corpectomy (vertebral body resection), partial	7	14	NEUROSURGERY	NEUROSURGERY	14
63306	Vertebral corpectomy (vertebral body resection), partial	1	14	NEUROSURGERY	NEUROSURGERY	14
63307	Vertebral corpectomy (vertebral body resection), partial	4	14	NEUROSURGERY	NEUROSURGERY	14
63610	Stereotactic stimulation of spinal cord, percutaneous,	6	05	ANESTHESIOLOGY	NEUROSURGERY	14
63615	Stereotactic biopsy, aspiration, or excision of lesion,	3	14	NEUROSURGERY	NEUROSURGERY	14
63700	Repair of meningocele; less than 5 cm diameter	26	20	ORTHOPEDIC SURGERY	NEUROSURGERY	14
63702	Repair of meningocele; larger than 5 cm diameter	7	14	NEUROSURGERY	NEUROSURGERY	14
63704	Repair of myelomeningocele; less than 5 cm diameter	6	14	NEUROSURGERY	NEUROSURGERY	14
63706	Repair of myelomeningocele; larger than 5 cm	4	14	NEUROSURGERY	NEUROSURGERY	14
63740	Creation of shunt, lumbar, subarachnoid-peritoneal, -	85	14	NEUROSURGERY	NEUROSURGERY	14
63746	Removal of entire lumbosubarachnoid shunt system	53	14	NEUROSURGERY	NEUROSURGERY	14
64410	Injection, anesthetic agent; phrenic nerve	76	33	THORACIC SURGERY	THORACIC SURGERY	33
64508	Injection, anesthetic agent; carotid sinus (separate	22	02	GENERAL SURGERY	ANESTHESIOLOGY	05
64560	Percutaneous implantation of neurostimulator	6	34	UROLOGY	NEUROSURGERY	14
64577	Incision for implantation of neurostimulator electrodes;	3	25	PHYSICAL MEDICINE AND	NEUROSURGERY	14
64580	Incision for implantation of neurostimulator electrodes;	29	02	GENERAL SURGERY	NEUROSURGERY	14
64605	Destruction by neurolytic agent, trigeminal nerve;	89	09	INTERVENTIONAL PAIN	NEUROSURGERY	14
64681	Destruction by neurolytic agent, with or without	92	05	ANESTHESIOLOGY	ANESTHESIOLOGY	05
64732	Transection or avulsion of; supraorbital nerve	16	14	NEUROSURGERY	NEUROSURGERY	14
64734	Transection or avulsion of; infraorbital nerve	31	14	NEUROSURGERY	NEUROSURGERY	14
64736	Transection or avulsion of; mental nerve	10	14	NEUROSURGERY	ORAL SURGERY	19

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64738	Transection or avulsion of; inferior alveolar nerve by	12	14	NEUROSURGERY	MAXILLOFACIAL SURGERY	85
64740	Transection or avulsion of; lingual nerve	7	04	OTOLARYNGOLOGY	MAXILLOFACIAL SURGERY	85
64742	Transection or avulsion of; facial nerve, differential or	75	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
64744	Transection or avulsion of; greater occipital nerve	96	14	NEUROSURGERY	NEUROSURGERY	14
64746	Transection or avulsion of; phrenic nerve	14	33	THORACIC SURGERY	THORACIC SURGERY	33
64752	Transection or avulsion of; vagus nerve (vagotomy),	10	02	GENERAL SURGERY	GENERAL SURGERY	02
64755	Transection or avulsion of; vagus nerves limited to	3	02	GENERAL SURGERY	GENERAL SURGERY	02
64760	Transection or avulsion of; vagus nerve (vagotomy),	35	02	GENERAL SURGERY	GENERAL SURGERY	02
64761	Transection or avulsion of; pudendal nerve	11	02	GENERAL SURGERY	OB-GYN	16
64763	Transection or avulsion of obturator nerve, extrapelvic,	1	24	PLASTIC AND	PLASTIC AND RECONSTUCTIVE SURGERY	24
64766	Transection or avulsion of obturator nerve, intrapelvic,	9	02	GENERAL SURGERY	GENERAL SURGERY	02
64771	Transection or avulsion of other cranial nerve,	45	04	OTOLARYNGOLOGY	NEUROSURGERY	14
64778	Excision of neuroma; digital nerve, each additional digit	23	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64786	Excision of neuroma; sciatic nerve	30	20	ORTHOPEDIC SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
64792	Excision of neurofibroma or neurolemmoma; extensive	81	14	NEUROSURGERY	NEUROSURGERY	14
64802	Sympathectomy, cervical	16	05	ANESTHESIOLOGY	NEUROSURGERY	14
64804	Sympathectomy, cervicothoracic	19	33	THORACIC SURGERY	NEUROSURGERY	14
64809	Sympathectomy, thoracolumbar	8	33	THORACIC SURGERY	NEUROSURGERY	14
64821	Sympathectomy; radial artery	58	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64822	Sympathectomy; ulnar artery	57	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64823	Sympathectomy; superficial palmar arch	69	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64835	Suture of one nerve; median motor thenar	42	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64836	Suture of one nerve; ulnar motor	45	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	24
64837	Suture of each additional nerve, hand or foot (List	17	24	PLASTIC AND	ORTHOPEDIC SURGERY	24
64840	Suture of posterior tibial nerve	8	09	INTERVENTIONAL PAIN	ORTHOPEDIC SURGERY	24
64858	Suture of sciatic nerve	4	14	NEUROSURGERY	ORTHOPEDIC SURGERY	20
64859	Suture of each additional major peripheral nerve (List	25	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
64861	Suture of; brachial plexus	6	24	PLASTIC AND	NEUROSURGERY	14
64864	Suture of facial nerve; extracranial	97	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
64865	Suture of facial nerve; infratemporal, with or without	22	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
64866	Anastomosis; facial-spinal accessory	5	04	OTOLARYNGOLOGY	PLASTIC AND RECONSTUCTIVE SURGERY	24
64868	Anastomosis; facial-hypoglossal	25	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
64872	Suture of nerve; requiring secondary or delayed suture	10	40	HAND SURGERY	ORTHOPEDIC SURGERY	20
64874	Suture of nerve; requiring extensive mobilization, or	12	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64885	Nerve graft (includes obtaining graft), head or neck; up	70	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
64886	Nerve graft (includes obtaining graft), head or neck;	81	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
64890	Nerve graft (includes obtaining graft), single strand,	51	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64891	Nerve graft (includes obtaining graft), single strand,	4	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
64892	Nerve graft (includes obtaining graft), single strand,	13	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
64893	Nerve graft (includes obtaining graft), single strand,	2	04	OTOLARYNGOLOGY	ORTHOPEDIC SURGERY	20

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64895	Nerve graft (includes obtaining graft), multiple strands	9	24	PLASTIC AND	ORTHOPEDIC SURGERY	20
64896	Nerve graft (includes obtaining graft), multiple strands	3	40	HAND SURGERY	ORTHOPEDIC SURGERY	20
64897	Nerve graft (includes obtaining graft), multiple strands	5	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64898	Nerve graft (includes obtaining graft), multiple strands	9	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
64901	Nerve graft, each additional nerve; single strand (List	22	04	OTOLARYNGOLOGY	ORTHOPEDIC SURGERY	20
64902	Nerve graft, each additional nerve; multiple strands	16	04	OTOLARYNGOLOGY	ORTHOPEDIC SURGERY	20
64905	Nerve pedicle transfer; first stage	16	14	NEUROSURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
64907	Nerve pedicle transfer; second stage	1	20	ORTHOPEDIC SURGERY	PLASTIC AND RECONSTUCTIVE SURGERY	24
64911	Nerve repair; with autogenous vein graft (includes	15	20	ORTHOPEDIC SURGERY	ORTHOPEDIC SURGERY	20
65091	Evisceration of ocular contents; without implant	80	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65112	Exenteration of orbit (does not include skin graft),	34	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65114	Exenteration of orbit (does not include skin graft),	28	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65125	Modification of ocular implant with placement or	25	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65130	Insertion of ocular implant secondary; after	25	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65135	Insertion of ocular implant secondary; after enucleation,	29	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65140	Insertion of ocular implant secondary; after enucleation,	24	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65150	Reinsertion of ocular implant; with or without	38	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65155	Reinsertion of ocular implant; with use of foreign	58	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65260	Removal of foreign body, intraocular; from posterior	14	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65272	Repair of laceration; conjunctiva, by mobilization and	49	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65273	Repair of laceration; conjunctiva, by mobilization and	17	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65290	Repair of wound, extraocular muscle, tendon and/or	56	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65781	Ocular surface reconstruction; limbal stem cell allograft	57	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65820	Goniotomy	76	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
65900	Removal of epithelial downgrowth, anterior chamber of	83	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
66155	Fistulization of sclera for glaucoma;	35	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
66165	Fistulization of sclera for glaucoma; iridencleisis or	5	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
66220	Repair of scleral staphyloma; without graft	19	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
66505	Iridotomy by stab incision (separate procedure); with	9	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
66600	Iridectomy, with corneoscleral or corneal section; for	70	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
66605	Iridectomy, with corneoscleral or corneal section; with	15	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
66700	Ciliary body destruction; diathermy	49	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
66920	Removal of lens material; intracapsular	93	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67115	Release of encircling material (posterior segment)	85	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67250	Scleral reinforcement (separate procedure); without	56	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67334	Strabismus surgery by posterior fixation suture	79	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67340	Strabismus surgery involving exploration and/or repair	90	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67346	Biopsy of extraocular muscle	39	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67415	Fine needle aspiration of orbital contents	64	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67430	Orbitotomy with bone flap or window, lateral approach	13	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18

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67440	Orbitotomy with bone flap or window, lateral approach	19	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67450	Orbitotomy with bone flap or window, lateral approach	83	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67570	Optic nerve decompression (eg, incision or fenestration	83	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67835	Correction of trichiasis; incision of lid margin, with free	73	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
67906	Repair of blepharoptosis; superior rectus technique	29	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
68371	Harvesting conjunctival allograft, living donor	16	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
68500	Excision of lacrimal gland (dacryoadenectomy), except	8	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
68505	Excision of lacrimal gland (dacryoadenectomy), except	43	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
68510	Biopsy of lacrimal gland	96	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
68540	Excision of lacrimal gland tumor; frontal approach	39	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
68550	Excision of lacrimal gland tumor; involving osteotomy	4	04	OTOLARYNGOLOGY	OPHTHALMOLOGY	18
68745	Conjunctivorhinostomy (fistulization of conjunctiva to	30	18	OPHTHALMOLOGY	OPHTHALMOLOGY	18
69155	Radical excision external auditory canal lesion; with	27	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69300	Otoplasty, protruding ear, with or without size reduction	36	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69320	Reconstruction external auditory canal for congenital	32	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69405	Eustachian tube catheterization, transtympanic	44	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69501	Transmastoid antrotomy (simple mastoidectomy)	73	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69505	Mastoidectomy; modified radical	96	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69511	Mastoidectomy; radical	52	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69530	Petrous apicectomy including radical mastoidectomy	19	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69550	Excision aural glomus tumor; transcanal	75	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69552	Excision aural glomus tumor; transmastoid	32	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69554	Excision aural glomus tumor; extended (extratemporal)	3	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69601	Revision mastoidectomy; resulting in complete	59	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69602	Revision mastoidectomy; resulting in modified radical	87	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69603	Revision mastoidectomy; resulting in radical	58	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69604	Revision mastoidectomy; resulting in tympanoplasty	54	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69605	Revision mastoidectomy; with apicectomy	2	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69650	Stapes mobilization	61	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69670	Mastoid obliteration (separate procedure)	74	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69676	Tympanic neurectomy	2	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69700	Closure postauricular fistula, mastoid (separate	17	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69711	Removal or repair of electromagnetic bone conduction	19	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69715	Implantation, osseointegrated implant, temporal bone,	9	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69717	Replacement (including removal of existing device),	16	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69718	Replacement (including removal of existing device),	3	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69720	Decompression facial nerve, intratemporal; lateral to	93	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69725	Decompression facial nerve, intratemporal; including	8	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69740	Suture facial nerve, intratemporal, with or without graft	10	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69745	Suture facial nerve, intratemporal, with or without graft	2	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04

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69802	Labyrinthotomy, with or without cryosurgery including	21	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69805	Endolymphatic sac operation; without shunt	52	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69820	Fenestration semicircular canal	7	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69840	Revision fenestration operation	3	18	OPHTHALMOLOGY	OTOLARYNGOLOGY	04
69905	Labyrinthectomy; transcanal	21	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69910	Labyrinthectomy; with mastoidectomy	88	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69915	Vestibular nerve section, translabyrinthine approach	10	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69950	Vestibular nerve section, transcranial approach	7	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69955	Total facial nerve decompression and/or repair (may	12	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69960	Decompression internal auditory canal	15	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
69970	Removal of tumor, temporal bone	30	04	OTOLARYNGOLOGY	OTOLARYNGOLOGY	04
70010	Myelography, posterior fossa, radiological supervision	60	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
70555	Magnetic resonance imaging, brain, functional MRI;	72	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
70557	Magnetic resonance (eg, proton) imaging, brain	69	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
70558	Magnetic resonance (eg, proton) imaging, brain	29	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
70559	Magnetic resonance (eg, proton) imaging, brain	90	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
74235	Removal of foreign body(s), esophageal, with use of	48	10	GASTROENTEROLOGY	DIAGNOSTIC RADIOLOGY	30
74291	Cholecystography, oral contrast; additional or repeat	7	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
74440	Vasography, vesiculography, or epididymography,	30	34	UROLOGY	UROLOGY	34
74445	Corpora cavernosography, radiological supervision and	84	34	UROLOGY	UROLOGY	34
74710	Pelvimetry, with or without placental localization	37	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation	4	30	DIAGNOSTIC RADIOLOGY	INTERVENTIONAL RADIOLOGY	94
74775	Perineogram (eg, vaginogram, for sex determination or	97	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
75731	Angiography, adrenal, unilateral, selective, radiological	52	06	CARDIOLOGY	CARDIOLOGY	06
75733	Angiography, adrenal, bilateral, selective, radiological	50	06	CARDIOLOGY	CARDIOLOGY	06
75801	Lymphangiography, extremity only, unilateral,	77	02	GENERAL SURGERY	GENERAL SURGERY	02
75803	Lymphangiography, extremity only, bilateral,	13	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
75805	Lymphangiography, pelvic/abdominal, unilateral,	16	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
75807	Lymphangiography, pelvic/abdominal, bilateral,	5	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
75810	Splenoportography, radiological supervision and	45	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
75840	Venography, adrenal, unilateral, selective, radiological	72	77	VASCULAR SURGERY	DIAGNOSTIC RADIOLOGY	30
75842	Venography, adrenal, bilateral, selective, radiological	27	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
75870	Venography, superior sagittal sinus, radiological	70	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
75880	Venography, orbital, radiological supervision and	12	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
75959	Placement of distal extension prosthesis(s) (delayed)	62	77	VASCULAR SURGERY	DIAGNOSTIC RADIOLOGY	30
75995	Transluminal atherectomy, visceral, radiological	26	77	VASCULAR SURGERY	DIAGNOSTIC RADIOLOGY	30
75996	Transluminal atherectomy, each additional visceral	11	02	GENERAL SURGERY	DIAGNOSTIC RADIOLOGY	30

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76010	Radiologic examination from nose to rectum for foreign	76	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
76150	Xeroradiography	36	09	INTERVENTIONAL PAIN	ORTHOPEDIC SURGERY	20
76529	Ophthalmic ultrasonic foreign body localization	30	18	OPHTHALMOLOGY	OPHTHALMOLOGY	30
76814	Ultrasound, pregnant uterus, real time with image	28	16	OBSTETRICS/GYNECOLOGY	OBSTETRICS/GYNECOLOGY	16
76885	Ultrasound, infant hips, real time with imaging	15	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
76886	Ultrasound, infant hips, real time with imaging	43	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
76941	Ultrasonic guidance for intrauterine fetal transfusion or	9	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
76945	Ultrasonic guidance for chorionic villus sampling,	65	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
76948	Ultrasonic guidance for aspiration of ova, imaging	12	16	OBSTETRICS/GYNECOLOGY	OB-GYN	16
77605	Hyperthermia, externally generated; deep (ie, heating	6	02	GENERAL SURGERY	RADIATION ONCOLOGY	92
77610	Hyperthermia generated by interstitial probe(s); 5 or	2	02	GENERAL SURGERY	RADIATION ONCOLOGY	92
77615	Hyperthermia generated by interstitial probe(s); more	3	92	RADIATION ONCOLOGY	RADIATION ONCOLOGY	92
77620	Hyperthermia generated by intracavitary probe(s)	33	02	GENERAL SURGERY	RADIATION ONCOLOGY	92
78003	Thyroid uptake; stimulation, suppression or discharge	95	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78016	Thyroid carcinoma metastases imaging; with additional studies (eg, urinary recovery)	55	36	NUCLEAR MEDICINE	NUCLEAR MEDICINE	36
78110	Plasma volume, radiopharmaceutical volume-dilution	14	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78111	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings	41	36	NUCLEAR MEDICINE	NUCLEAR MEDICINE	36
78130	Red cell survival study;	15	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78135	Red cell survival study; differential organ/tissue kinetics	21	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78191	Platelet survival study	34	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78230	Salivary gland imaging;	42	30	DIAGNOSTIC RADIOLOGY	NUCLEAR MEDICINE	36
78231	Salivary gland imaging; with serial images	65	36	NUCLEAR MEDICINE	NUCLEAR MEDICINE	36
78232	Salivary gland function study	29	30	DIAGNOSTIC RADIOLOGY	NUCLEAR MEDICINE	36
78261	Gastric mucosa imaging	84	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78270	Vitamin B-12 absorption study (eg, Schilling test);	30	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78271	Vitamin B-12 absorption study (eg, Schilling test); with	2	22	PATHOLOGY	DIAGNOSTIC RADIOLOGY	30
78272	Vitamin B-12 absorption studies combined, with and	12	11	INTERNAL MEDICINE	DIAGNOSTIC RADIOLOGY	30
78282	Gastrointestinal protein loss	16	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78600	Brain imaging, less than 4 static views;	74	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78609	Brain imaging, positron emission tomography (PET);	86	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
78635	Cerebrospinal fluid flow, imaging (not including	58	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
79200	Radiopharmaceutical therapy, by intracavitary	23	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
79300	Radiopharmaceutical therapy, by interstitial radioactive	26	92	RADIATION ONCOLOGY	RADIATION ONCOLOGY	92
79440	Radiopharmaceutical therapy, by intra-articular	28	36	NUCLEAR MEDICINE	DIAGNOSTIC RADIOLOGY	30
86327	Immunoelectrophoresis; crossed (2-dimensional assay)	77	69	INDEPENDENT LABORATORY	PATHOLOGY	22
88125	Cytopathology, forensic (eg, sperm)	19	22	PATHOLOGY	PATHOLOGY	22
88371	Protein analysis of tissue by Western Blot, with		69	INDEPENDENT LABORATORY	PATHOLOGY	22
88380	Microdissection (ie, sample preparation of	84	22	PATHOLOGY	PATHOLOGY	22

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88385	Array-based evaluation of multiple molecular probes;	17	69	INDEPENDENT LABORATORY	PATHOLOGY	22
88386	Array-based evaluation of multiple molecular probes;	43	83	HEMATOLOGY/ONCOLOGY	PATHOLOGY	22
89105	Duodenal intubation and aspiration; collection of	98	22	PATHOLOGY	GASTROENTEROLOGY	10
89132	Gastric intubation and aspiration, diagnostic, each	3	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
89135	Gastric intubation, aspiration, and fractional collections	16	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
90466	Immunization administration younger than 8 years of	38	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37
90467	Immunization administration younger than age 8 years	3	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37
90468	Immunization administration younger than age 8 years	1	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37
90474	Immunization administration by intranasal or oral route;	46	44	INFECTIOUS DISEASE	FAMILY PRACTICE	08
90828	Individual psychotherapy, interactive, using play	32	68	CLINICAL PSYCHOLOGIST	CLINICAL PSYCHOLOGIST	68
90829	Individual psychotherapy, interactive, using play	48	26	PSYCHIATRY	PSYCHIATRY	26
90865	Narcosynthesis for psychiatric diagnostic and	94	26	PSYCHIATRY	PSYCHIATRY	26
91000	Esophageal intubation and collection of washings for	95	11	INTERNAL MEDICINE	GASTROENTEROLOGY	10
91022	Duodenal motility (manometric) study	75	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
91040	Esophageal balloon distension provocation study	23	06	CARDIOLOGY	GASTROENTEROLOGY	10
91052	Gastric analysis test with injection of stimulant of	76	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
91132	Electrogastrography, diagnostic, transcutaneous;	36	10	GASTROENTEROLOGY	GASTROENTEROLOGY	10
92015	Determination of refractive state	1	18	OPHTHALMOLOGY	OPTOMETRY	41
92316	Prescription of optical and physical characteristics of	63	18	OPHTHALMOLOGY	OPTOMETRY	41
92317	Prescription of optical and physical characteristics of	8	41	OPTOMETRY	OPTOMETRY	41
92551	Screening test, pure tone, air only	1	97	PHYSICIANS ASSISTANT	FAMILY PRACTICE	08
92596	Ear protector attenuation measurements	22	04	OTOLARYNGOLOGY	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92601	Diagnostic analysis of cochlear implant, patient	2	04	OTOLARYNGOLOGY	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92602	Diagnostic analysis of cochlear implant, patient	9	04	OTOLARYNGOLOGY	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92608	Evaluation for prescription for speech-generating	94	13	NEUROLOGY	OTOLARYNGOLOGY	04
92621	Evaluation of central auditory function, with report;	15	64	AUDIOLOGIST (BILLING	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92640	Diagnostic analysis with programming of auditory	9	18	OPHTHALMOLOGY	AUDIOLOGIST (BILLING INDEPENDENTLY)	64
92970	Cardioassist-method of circulatory assist; internal	48	06	CARDIOLOGY	CARDIOLOGY	06
92977	Thrombolysis, coronary; by intravenous infusion	22	93	EMERGENCY MEDICINE	CARDIOLOGY	06
92990	Percutaneous balloon valvuloplasty; pulmonary valve	26	06	CARDIOLOGY	CARDIOLOGY	06
92992	Atrial septectomy or septostomy; transvenous method,	1	06	CARDIOLOGY	CARDIOLOGY	06
92997	Percutaneous transluminal pulmonary artery balloon	40	06	CARDIOLOGY	CARDIOLOGY	06
92998	Percutaneous transluminal pulmonary artery balloon	9	06	CARDIOLOGY	CARDIOLOGY	06
93514	Left heart catheterization by left ventricular puncture	22	06	CARDIOLOGY	CARDIOLOGY	06
93532	Combined right heart catheterization and transseptal	15	06	CARDIOLOGY	CARDIOLOGY	06
93533	Combined right heart catheterization and transseptal	45	06	CARDIOLOGY	CARDIOLOGY	06
93581	Percutaneous transcatheter closure of a congenital	29	06	CARDIOLOGY	CARDIOLOGY	06
93615	Esophageal recording of atrial electrogram with or	59	06	CARDIOLOGY	CARDIOLOGY	06
93616	Esophageal recording of atrial electrogram with or	83	05	ANESTHESIOLOGY	CARDIOLOGY	06
93982	Noninvasive physiologic study of implanted wireless	6	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30

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94610	Intrapulmonary surfactant administration by a physician	22	29	PULMONARY DISEASE	PEDIATRIC MEDICINE	37
95071	Inhalation bronchial challenge testing (not including	7	03	ALLERGY/IMMUNOLOGY	ALLERGY/IMMUNOLOGY	03
95199	Unlisted allergy/clinical immunologic service or	41	04	OTOLARYNGOLOGY	ALLERGY/IMMUNOLOGY	03
95875	Ischemic limb exercise test with serial specimen(s)	28	13	NEUROLOGY	NEUROLOGY	13
95966	Magnetoencephalography (MEG), recording and	90	13	NEUROLOGY	NEUROLOGY	13
95967	Magnetoencephalography (MEG), recording and	72	13	NEUROLOGY	NEUROLOGY	13
96003	Dynamic fine wire electromyography, during walking or	88	28	COLORECTAL	PHYSICAL THERAPIST (INDEP. PRACTICE)	65
96020	Neurofunctional testing selection and administration	4	30	DIAGNOSTIC RADIOLOGY	NEUROLOGY	13
96440	Chemotherapy administration into pleural cavity,	73	33	THORACIC SURGERY	THORACIC SURGERY	33
96571	Photodynamic therapy by endoscopic application of	22	29	PULMONARY DISEASE	GASTROENTEROLOGY	10
97010	Application of a modality to 1 or more areas; hot or cold	1	01	GENERAL PRACTICE	PHYSICAL THERAPIST (INDEP. PRACTICE)	65
99170	Anogenital examination with colposcopic magnification	10	10	GASTROENTEROLOGY	PEDIATRIC MEDICINE	37
99175	Ipecac or similar administration for individual emesis	13	93	EMERGENCY MEDICINE	EMERGENCY MEDICINE	08
99358	Prolonged evaluation and management service before	1	18	OPHTHALMOLOGY	FAMILY PRACTICE	08
99397	Periodic comprehensive preventive medicine	3	08	FAMILY PRACTICE	FAMILY PRACTICE	08
99460	Initial hospital or birthing center care, per day, for	2	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37
99462	Subsequent hospital care, per day, for evaluation and	4	16	OBSTETRICS/GYNECOLOGY	PEDIATRIC MEDICINE	37
99463	Initial hospital or birthing center care, per day, for	4	11	INTERNAL MEDICINE	PEDIATRIC MEDICINE	37
99464	Attendance at delivery (when requested by the	2	01	GENERAL PRACTICE	PEDIATRIC MEDICINE	37
99466	Critical care services delivered by a physician, face-to-	19	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37
99467	Critical care services delivered by a physician, face-to-	6	08	FAMILY PRACTICE	PEDIATRIC MEDICINE	37
99468	Initial inpatient neonatal critical care, per day, for the	16	93	EMERGENCY MEDICINE	PEDIATRIC MEDICINE	37
99469	Subsequent inpatient neonatal critical care, per day, for	27	11	INTERNAL MEDICINE	PEDIATRIC MEDICINE	37
99471	Initial inpatient pediatric critical care, per day, for the	39	37	PEDIATRIC MEDICINE	PEDIATRIC MEDICINE	37
99478	Subsequent intensive care, per day, for the evaluation	10	02	GENERAL SURGERY	PEDIATRIC MEDICINE	37
99479	Subsequent intensive care, per day, for the evaluation	13	37	PEDIATRIC MEDICINE	PEDIATRIC MEDICINE	37
99480	Subsequent intensive care, per day, for the evaluation	67	11	INTERNAL MEDICINE	PEDIATRIC MEDICINE	37
G0118	Glaucoma screening for high risk patient furnished	5	41	OPTOMETRY	OPHTHALMOLOGY	18
G0120	Colorectal cancer screening; alternative to G0105,	84	30	DIAGNOSTIC RADIOLOGY	DIAGNOSTIC RADIOLOGY	30
G0329	Electromagnetic therapy, to one or more areas for	10	48	PODIATRY	PODIARY	48
Q0035	Cardiokymography	40	38	GERIATRIC MEDICINE	CARDIOLOGY	06

AMA/Specialty Society RVS Update Committee **Tab 37**
RUC HCPAC Review Board Meeting
January 29, 2009

Members Present:

Arthur Traugott, MD, Chair	Anthony Hamm, DC
Lloyd Smith, DPM, Co-Chair	Emily H. Hill, PA-C
Katherine Bradley, PhD, RN	William J. Mangold, Jr., MD
Michael Chaglasian, OD	Doris Tomer, LCSW
Robert Fifer, PhD	Erik van Doorne, PT, DPT
Mary Foto, OTR	Jane White, PhD, RD, FADA

I. CMS Update

Edith Hambrick, MD, provided a CMS update and informed the HCPAC that CMS is currently awaiting appointment of the new CMS Administrator. Doctor Hambrick also suggested that the organizations represented on the HCPAC may bring issues to CMS' attention at this time for the proposed rulemaking process.

II. CMS Request: Relative Value Recommendations for *CPT 2010*:

Lower Extremity Ultrasound

The Five-Year Review Identification Workgroup reviewed Code 76880 *Ultrasound, extremity, nonvascular, real time with image documentation* as part of its CMS-initiated 114 Fastest Growing Procedures screen. The American Podiatric Medical Association (APMA) rescinded its level of interest, as it stated that podiatrists are not the dominant specialty performing this service. The Workgroup identified that this services is predominantly provided by podiatry in the office setting, but is performed by diagnostic radiologists primarily in the facility setting. The HCPAC understands that the RUC Five-Year Review Identification Workgroup has recommended a joint CPT/RUC Workgroup review this and other services that utilize significantly less expensive technology than originally valued (eg, ultrasound room v. handheld ultrasound).

Speech-Language Pathology Services

92611

The HCPAC reviewed the American Speech-Language-Hearing Association (ASHA) recommendation for 92611 *Motion fluoroscopic evaluation of swallowing function by cine or video recording.* The HCPAC recognized that since this speech language pathology service is converting from practice expense only inputs to work, that survey respondents had limited reference services to identify with. The HCPAC reviewed the pre-service time and determined that 10 minutes of pre-service time appropriately accounted for the time required to review the patients medical records, review the patient's history, prepare the barium liquids, prepare items of different consistencies and dress in the appropriate radiation deterrent gowns. The HCPAC reviewed the intra-service time and determined that 30 minutes appropriately accounted for the time to feed patients the numerous substances while watching the video fluoroscopy and make determinations on the subsequent liquid consistencies to utilize and patient postures employ. The HCPAC reviewed the immediate post-service time and recommended reducing the survey respondents and specialty society recommended time from 15 minutes to 10 minutes. The HCPAC determined that 10 minutes appropriately accounts for time required discussing findings with the patient/family, writing a report and communicating necessary information with the referring physician.

The HCPAC compared 92611 to 97001 *Physical therapy evaluation* (work RVU = 1.20, 4 minutes pre-service, 30 minutes intra-service, and 8 minute post-service time) and 92602 *Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming* (work RVU = 1.30, 5 minutes pre-service, 50 minutes intra-service, and 10 minutes immediate post-service time). The HCPAC determined that 92611 is more intense than 97001 and 92602 as more management and following strategy determination is required.

The HCPAC also compared 92611 to code 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.34, pre-service time = 4 minutes, intra-service time = 20 minutes and immediate post-service time = 5 minutes), and determined that the survey 25th percentile work RVU of 1.34 is exactly the same as 99203 and appropriately accounts for the work required to perform this service. **The HCPAC recommends a work RVU of 1.34, 10 minutes pre-service time, 30 minutes intra-service time, and 10 minutes immediate post-service time for code 92611.**

Practice Expense

The HCPAC recommends removing the previous speech language pathologist's time from the practice expense inputs as well as replacing outdated recording output VHS tape with a DVD for the non-facility setting for code 92611.

92526

The HCPAC reviewed code 92526 *Treatment of swallowing dysfunction and/or oral function for feeding.* After a robust discussion of the intra-service work and episodes of therapy, the HCPAC recommends postponing recommending a work value for this service until additional frequency data is gathered and the RUC has reviewed the evaluation code, 92610 *Evaluation of oral and pharyngeal swallowing function*, associated with this treatment code.

III. Other

HCPAC Co-Chair and Alternate Co-Chair

AMA staff indicated that the first term for the HCPAC Co-Chair, Lloyd Smith, DPM, and HCPAC Alternate Co-Chair, Emily Hill, PA-C, will conclude after the April 2009 HCPAC meeting. HCPAC Co-Chair and alternate Co-Chairs are eligible to serve two 2-year terms. AMA staff will be requesting nominations following this meeting and voting for these seats will occur at the April 2009 HCPAC meeting.

AMA/Specialty Society RVS Update Committee **Tab 38**
Five-Year Review Identification Workgroup
January 29, 2009

Members Present: Barbara Levy, MD (Chair), James Blankenship, MD, Dale Blasier, MD, Katherine Bradley, PhD, RN, Brenda Lewis, MD, Thomas Felger, MD, Gregory Kwasny, MD, William J. Mangold, Jr., MD, Lawrence Martinelli, MD, Geraldine McGinty, MD, Marc Raphaelson, MD, Robert Zwolak, MD

I. CMS Request for Review of 114 High Volume Growth Services

a. Discussion and Review of 32 Codes that May Need to be Surveyed

Prior to the review of the 32 codes that may need to be surveyed, Doctor Levy reminded the Workgroup that at the October 2008 meeting of the Workgroup, these services were originally recommended to be surveyed based on the committee's review of each service. The Workgroup had a general discussion of the timeline and the need to respond to CMS's original request to review these 114 services. In order to provide a complete and timely response, the Workgroup agreed that for any service where a survey is recommended, that the survey be conducted and recommendations presented to the RUC at the October 2009 RUC meeting. However, the Workgroup would welcome surveys by April and would understand if some specialties (e.g., radiology) choose to split their codes between April 2009, October 2009, and February 2010. **The Workgroup recommends that for all recommendations to survey, except where otherwise stated, that the survey be conducted and RVU recommendations be presented in October 2009, allowing for April 2009 presentations if desired and requiring that all issues be presented no later than February 2010.**

The Workgroup also noted that a request to survey does not imply that an increase in utilization automatically translates to misvaluation. Rather, many of these codes have never been validated by the RUC and have now been presented to the RUC via multiple screens.

Doctor Levy continued by reminding the Workgroup that the recommendation of the RUC was for staff to solicit input from all specialty societies to identify any relevant codes from a family that may need to be surveyed in addition to the code in question, provide any special concerns regarding the timing and scheduling of a survey, and give any other concerns that the RUC should be aware of before recommending to CMS that the code be surveyed. The Workgroup reviewed and discussed the comments on each code and made the following recommendations (in descending order of Medicare utilization):

Code	Recommendation
92135	The specialty noted that the increase in utilization was due to a shift in the primary diagnosis for this service from glaucoma to macular degeneration. The Workgroup noted that this should be reflected in a clinical vignette. **The Workgroup recommends that this service be surveyed.**

Code	Recommendation
71250	The specialty commented that utilization for this services is due to improved technology and effectiveness of the procedure. Further, 71260 was recently reviewed at the Third Five-Year Review and resulted in no change in the work value. The Workgroup agreed that because of the high volume of the procedure and the fact that it has not been reviewed by the RUC that it would have also been identified as Harvard-valued with greater than one million claims and should be surveyed. **The Workgroup recommends that this service be surveyed.**
92136	The specialty commented that 92136 is supplanting ultrasound technique for assessing the eye prior to cataract surgery. As the utilization for this service has increased, the ultrasound code (76519) has decreased by a commensurate amount. 76519 and 92136 have similar Medicare payment rates. **The Workgroup agreed with the specialty society and recommends that this service be removed from this screen.**
67028	The specialty society recommends that this service be surveyed and the Workgroup agreed. **The Workgroup recommends that 67028 be surveyed.**
71275	ACR indicated that some of the utilization growth replaces other services (e.g., 78585). Also, some of the growth may be due to miscoding of coronary CTA studies and development of Category III codes in 2008 should eliminate this coding. Further, the procedure was recently reviewed by the RUC in 2001. **The Workgroup recommends that the specialty draft an informational article in CPT Assistant article and a comparable ACR publication and review the service again in 2 years (September 2011).**
93922 93923 93924 (93922-93924)	The Workgroup accepted the specialty recommendation to refer these services to CPT as there are a number of examples included in the code descriptor. **The entire family of services (93922, 93923, 93924) are recommended to be referred to CPT.**
76536	The specialty noted that utilization for this service may have increased in part due to the higher incidence of thyroid cancer. However, the service has never been RUC reviewed. **The Workgroup recommends that this service be surveyed.**
72125 72128 (72125-72133)	The specialty commented that as the utilization of these services has increased, other procedures representing older technologies have decreased (e.g., plain films). However, due to the high utilization and the fact that the services have never been reviewed by the RUC, they should be surveyed. **The Workgroup recommends that 72125 and 72128 as well as the entire family of CT spine services (72125-72133) be surveyed. The RUC agreed that radiology be allowed flexibility in identifying the immediate family and allowed to address via CPT if needed.**
92285	The specialty noted that utilization has increased due to the availability of newer and improved equipment. **The Workgroup recommends that 92285 be surveyed for work and practice expense.**

Code	Recommendation
73700 (73700-73706)	The specialty commented that the utilization of this service has increased due to changes in clinical practice. The service has never been reviewed by the RUC. **The Workgroup recommends that this service and the entire family of CT lower extremity services (73700-73706) be surveyed.**
93976	The specialty commented that the increase in utilization is due to physicians performing ultrasound with color and billing this service inappropriately. The specialty added that there are relatively new CPT instructions that should result in more appropriate use. **The Workgroup agreed and recommends that this service be reviewed again in two years (September 2011).**
69100	The specialty society recommends that this service be surveyed. **The Workgroup agrees with the specialty and recommends that 69100 be surveyed.**
64447	The specialty society recommends that this service be surveyed. **The Workgroup agrees with the specialty and recommends that 64447 be surveyed.**
64415	The specialty society recommends that this service be surveyed. **The Workgroup agrees with the specialty and recommends that 64415 be surveyed.**
64445	The specialty society recommends that this service be surveyed. **The Workgroup agrees with the specialty and recommends that 64445 be surveyed.**
73200 (73200-73202)	The specialty commented that as the utilization of this service has increased due to appropriate changes in clinical practice. The service has never been reviewed by the RUC. **The Workgroup recommends that this service and the entire family of CT upper extremity services (73200-73202) be surveyed.**
22851	The specialty has requested data from CMS, which includes the number of units reported by one physician during the same visit. The specialty has indicated an interest in editing the CPT descriptor to disallow bone graft, which is currently in the descriptor. The specialty is also in the process of developing a CPT Assistant article to clarify appropriate reporting. **The Workgroup recommends that 22851 be referred to CPT.**
92587	The specialty noted that this is now a very useful test for a wider range of patients. Previously, these patients were diagnosed via MRI, whereas this service is less expensive. The Workgroup noted that it is unclear who is performing this procedure and the practice expense inputs do not match what the specialties presented. **The Workgroup recommends that this service be referred to CPT and subsequently surveyed for physician work and practice expense be reviewed.**
73218 (73221)	The specialties commented that the increase in utilization is most likely due to inappropriate coding. Rheumatologists have been reporting this service incorrectly and should instead use 73221. **The Workgroup recommends that ACRh publish an article within their coding publication and draft a CPT Assistant Q&A. The Workgroup also recommends that it review this service as well as 73221 again in two years (September 2011).**

Code	Recommendation
61795	The specialty commented that the descriptor does not accurately describe the work and recommends that the service be referred to CPT to create several more granular codes. **The Workgroup agreed and recommends that the service be referred to CPT.**
29822	The specialty noted that the increase in utilization represents a trend away from open procedures and migration to arthroscopic procedures. The open procedure, 23420, has decreased over the same period that 29822 has increased, by a commensurate amount. **The Workgroup agreed that recommended that 29822 be removed from this screen.**
73580 27370	The specialty commented that these codes were reviewed through the RUC's high volume growth screen and removed from the screen. The increase in utilization is due to a non-coverage decision for arthroscopic lavage. Physicians using these codes to report different procedures. **The Workgroup recommends that these be referred to CPT for possible deletion of 73580 and 27370 and creation of a new code accurately describing the procedure that is being performed, including the radiologic guidance in the procedure codes.**
23430	The specialty society recommends that this service be surveyed. **The Workgroup agrees with the specialty and recommends 23430 be surveyed.**
95956 (95950, 95953)	The specialty society recommends that this service as well as several others within the family be surveyed. **The Workgroup agrees with the specialty and recommends 95950, 95953, and 95956 be surveyed.**
63056	The specialty noted that the increase in utilization may be due to some inappropriate reporting of procedures that should be described using 62287 and another procedure that does not have a CPT code. **The Workgroup recommends referral to CPT for changes to the instructions and possible creation of a new CPT code.**
47490	The Workgroup commented that the hospital visits and work value appear inappropriate and that the code should be revised at CPT to include S&I by any method to account for typical procedure. The number of hospital visits varies widely among physicians (i.e., who is managing post-operative care) and it would be more appropriate to change this service to a 000 day global procedure. **The Workgroup agreed and recommends that this service be referred to CPT to include a code to include guidance. Further, the Workgroup recommends that it be valued as a 000 day global procedure.**
69801	The Workgroup agreed with the specialty that the typical patient and site of service has changed. In addition, the service has never been reviewed by the RUC and should be surveyed. **The Workgroup recommends that 69801 be surveyed.**
26480	The specialty commented that there has been an increase in transfer of tendon procedures. This is not due to any decrease in other procedures, but were simply left untreated in the past. **The specialty agreed that a survey is necessary. The Workgroup recommends that 26480 be surveyed.**

Code	Recommendation
63655	The specialty society noted that this service will be surveyed with other new codes for April 2009. **The Workgroup recommends that 63655 be surveyed with the other neurostimulator codes already scheduled for April 2009.**
93652	The specialty society recommends that this service be surveyed. **The Workgroup agrees with the specialty and recommends 93652 be surveyed. Due to the significant number of issues the specialty must address, the Workgroup asked that these services be presented by February 2010.**

b. Review of Services Requiring Historical Data from RUC Staff (22214, 22843, 22849)

At the October 2008 Workgroup meeting, recommendations for several services were deferred to allow staff to research and provide more detailed histories for the Workgroup's consideration. Staff's research was presented and the Workgroup heard from the specialty before making the following recommendations:

Code	Recommendation
22214	Staff confirmed that 22214 was not surveyed at the first Five-Year Review. The specialty noted that this procedure may be inappropriately reported with laminectomy procedures. In 2008, the specialty developed changes to the CPT instructions, which will become CCI edits limiting the ability of 22214 to be reported with laminectomy procedures. **The Workgroup recommends that it review this service again in two years (September 2011).**
22843	Staff noted that this service was valued by the RUC, reduced in value by CMS and later increased in value by CMS. The specialty noted that the increase in volume is relatively small and the anchor code 22840 was recently reviewed during the Third Five-Year Review. At that time, the RUC recommended no change in work RVU. **The Workgroup agrees with the specialty and recommends that the service be removed from this screen.**
22849	Staff confirmed that 22849 was not surveyed at the first Five-Year Review. The specialty noted that this procedure may be inappropriately reported with other reinsertion procedures as this should be a stand-alone service. **The Workgroup recommends that the specialty develop changes to the CPT instructions and/or parenthetical to limit reporting with other procedures. Further, the Workgroup recommends that it review this service again in two years (September 2011).**

c. Review of Codes that Require Additional Information from Specialty (10022, 13120, 13121, 13122, 20550, 20551, 20926, G0268)

At the October 2008 Workgroup meeting, recommendations for several services were deferred to allow specialty societies to provide additional data to the Workgroup for consideration. Specialties were asked to provide updates at this meeting for the Workgroup's information and consideration. Specialties provided information on the following services and the Workgroup took these actions:

Code	Recommendation
10022	The specialty indicated that some services are decreasing in utilization as 10022 has increased. The Workgroup asked for specific codes to review the changes. The specialty indicated that 10022 has increased while more invasive biopsy and excision procedures, including 19101, 19120, 19125, have decreased commensurate with the changes in utilization for 10022. **The Workgroup recommends removing 10022 from this screen.**
13120 13121 13122	The Workgroup believed that 13120, 13121, and 13122 were regularly performed at the same time as excision of lesion services and may need to be referred to CPT to create bundled services. However, the specialty society provided a robust analysis of utilization data showing that this family of codes is not typically reported by the same physician at the time of any excision codes. The Workgroup reviewed and accepted the data. **The Workgroup recommends that this service be reviewed again in 2 years. The Workgroup recommends that the specialty develop a CPT Assistant article to provide correct coding instructions.**
20550 20551 20926	The Workgroup requested the number of units of 20551 and 20550 billed on the same day by the same provider as well as the number and level of evaluation and management services reported at the same time as the 20551 and 20550. The Workgroup also requested similar data for 20926. The specialty society indicated that they believed the Workgroup would submit this request to CMS. **The Workgroup noted that the specialty is responsible for soliciting CMS for the information and asked the specialty to formally request the data from CMS and copy RUC staff. The Workgroup will review the service and the data at its April 2009 meeting.**
G0268	The Workgroup requested that the specialty request that CMS delete G0268 as the service is currently described by 69210. However, CMS is not likely to delete G0268 due to payment policy issues. The Workgroup noted that while the utilization for G0268 has increased, utilization for other cerumen removal codes have decreased. **The Workgroup recommends that G0268 be removed from this screen.**

d. Request to Change Recommendation (G0181)

The Workgroup reviewed the request from the American Academy of Family Physicians, American Academy of Home Care Physicians, American College of Physicians, and American Geriatrics Society regarding the RUC's recommendation for the specialty societies to develop a coding change proposal to create a Category I CPT code to describe the work performed in G0181. The Workgroup recommended and the RUC approved this action at the October 2008 RUC meeting. Shortly, thereafter the specialties informed the RUC that such an action would be unnecessary as a Category I CPT code describing the work of G0181 already exists, 99375. **As such, the Workgroup recommends changing its original recommendation from "refer to CPT" to "remove from screen."**

e. Change in APMA LOI for 76880

At the October 2008 RUC Meeting, the RUC approved the recommendation of the American Podiatric Medical Association to survey 76880, *Ultrasound, lower extremity*. APMA indicated a level 1 interest in

the code. However, the APMA later notified the RUC that it rescinds its level of interest to survey 76880, as it is not the dominant specialty. Specifically, the APMA noted that the physician work component of 76880 is more commonly performed by Diagnostic Radiology. According to the 2007 Medicare utilization data, the physician work component of 76880 (which is a PC/TC split) is reported 32 percent of the time by Podiatry and 44 percent by Diagnostic Radiology. However, Podiatry is the dominant provider of the technical component of the code, providing slightly more than 50 percent of the technical component.

The American College of Radiology indicated its willingness to take interest in the service. The ACR noted that the availability of handheld ultrasound equipment has enabled podiatry and other specialties to perform this and other similar procedures within their offices, which is driving the increase in utilization. The Workgroup noted that value of 76880 includes the ultrasound room, which is priced significantly higher than the handheld device. The Workgroup agreed that this is an issue that may need to be addressed through either CPT changes and/or significant changes in the practice expense and possibly work. Some workgroup members believe that there may be other services that were valued using larger, more expensive, and more sophisticated equipment where there is now smaller and more affordable equipment to perform a similar procedure. **The Workgroup recommends the creation of a joint CPT and RUC workgroup to research this issue to identify similar services and develop recommendations to appropriately describe and/or address the valuation of these services.**

II. Discussion and Timeline for Survey of Nine Harvard-Valued Codes (73510, 73610, 73630, 88312, 88313, 88304, 88305, 90935, 93042)

CMS indicated in the July 2008 NPRM that the Agency requests the RUC to review Harvard-valued codes. At its October 2008 meeting, the RUC recommended an initial review of the nine Harvard-valued codes with utilization greater than 1,000,000. The RUC also approved a process to initiate the review. The nine services (73510, 73610, 73630, 88304, 88305, 88312, 88313, 90935, 93042) were distributed to all specialties with a request for interested specialties to submit other codes that may need to be reviewed with these codes (ie, those within the same family), projected timeline for review, and any other special concerns. The Workgroup considered the responses and made the following recommendations:

Code	Recommendation
73510 73610 73630	The Workgroup agreed these services require a review, but that a complete survey may not be the appropriate mechanism. The specialty noted that it would be very difficult to differentiate the relatively low work values. **The Workgroup recommends that the specialty work with the Research Subcommittee to develop an appropriate survey or other method to validate valuation for these services with small RVUs (e.g., 0.17). Further, the Workgroup recommends that a survey method be developed and implemented, and the recommendations be presented to the RUC no later than the February 2010 meeting.**

Code	Recommendation
88304 88305 (88300-88309)	The Workgroup reviewed the specialties comments on both families of services (tissue exams and special stains). CAP commented that the Harvard studies used many vignettes per code and there were more than 180 pathologists surveyed. Conducting a standard RUC survey for these services may not produce data that is any more precise than the original Harvard services and may not be feasible. However, the Workgroup agreed that a survey to validate physician time and valuation is necessary, even if it is not the standard RUC survey. **The Workgroup recommends that the specialty work with the Research Subcommittee to develop an appropriate survey for he entire family of pathology tissue exam codes. Further, the Workgroup recommends that a survey be developed and implemented, and the recommendations be presented to the RUC no later than the February 2010 meeting, with October 2009 strongly preferred.**
88312 88313 (88312-88314)	The Workgroup reviewed the specialties comments on both families of services (tissue exams and special stains). CAP commented that the Harvard studies used many vignettes per code and there were more than 180 pathologists surveyed. Conducting a standard RUC survey for these services may not produce data that is any more precise than the original Harvard services and may not be feasible. However, the Workgroup agreed that a survey to validate physician time and valuation is necessary, even if it is not the standard RUC survey. **The Workgroup recommends that the specialty work with the Research Subcommittee to develop an appropriate survey for he entire family of special stain codes. Further, the Workgroup recommends that a survey be developed and implemented, and the recommendations be presented to the RUC no later than the February 2010 meeting, with October 2009 strongly preferred.**
90935 (90935-90947)	RPA indicated that it will conduct a survey of 90935 as well as 90937, 90945, and 90947, the other codes within the family. **The Workgroup agreed and recommends that the specialty conduct a survey and present the recommendations to the RUC no later than February 2010.**
93042 (93040-93042)	ACEP and ACC indicated that they will conduct a survey of 93042 as well as 93040 and 93042, the other codes within the family. **The Workgroup agreed and recommends that the specialty conduct a survey and present the recommendations to the RUC no later than February 2010, with October 2009 strongly preferred.**

III. Review of Services Identified in the 2009 Final Rule (93230, 93233, 61796, 61797, 61798, 61799, 63620, and 63621)

In the 2009 Final Rule for physician payment, CMS requested review of two cardiac device monitoring codes and rejected the RUC recommendations for six stereotactic radiosurgery codes. Staff informed the Workgroup that **the two cardiac device monitoring codes will be placed on the Level of Interest for the April 2009 RUC meeting**, as is the standard procedure for addressing CMS requests to review procedures. The specialty took note of this and will discuss this issue. With respect to the stereotactic radiosurgery procedures, the specialty informed the Workgroup that it has approached CMS and requested a refinement panel to review the work RVUs for each of the six codes. The Workgroup

recommends that no further action be taken on these procedures until CMS makes a determination following the meeting of the refinement panel's review.

IV. Codes Requiring More Data from CMS (76970, 94450, 94014, 94015, 94016, G0237, G0238)

The Workgroup reviewed the data submitted by CMS in response to these seven issues and clarified that the RUC was requesting CMS to investigate several of these issues. CMS indicated an understanding of this recommendation and assured the Workgroup that the Agency will be investigating each of these issues. The Workgroup will note this in its records and will remove each issue from its respective screen. **The Workgroup recommends that the RUC evaluations of 76790, 94450, 94014, 94015, 94016, G0237, and G0238 are complete upon the referral of the RUC's articulated concerns to CMS.**

V. Timeline and General Discussion of 2010 Five-Year Review

The Workgroup reviewed the below timeline for the 2010 Five-Year Review. Doctor Levy informed the Workgroup that a recommendation to include a timeline, general procedures, and specific issues for review must be developed and provided to the RUC for consideration at the April 2009 RUC meeting. The RUC will then finalize and submit to CMS a letter including any such issues by May 31, 2009 for consideration in the Proposed Rule for the 2010 physician fee schedule.

Five-Year Review Timetable

February 2010	CMS staff to send AMA staff list of codes to be reviewed, along with supporting documentation.
February 4-7, 2010	Research Subcommittee to review any changes to the existing RUC survey instrument.
February 16, 2010	AMA to send Level of Interest (LOI) forms to all specialty societies and HCPAC organizations. LOI package to include all materials received by CMS.
March 16, 2010	Responses to the LOI due to the AMA.
March 2010	Five-Year Review Workgroup to Review Comment Letters for codes in which there is no interest expressed to determine next steps for the review of these services.
April 28 – May 2, 2010	Summary of codes under review and specialty society assignments Research Subcommittee to review any alternative methodologies introduced.
May 10, 2010	Surveys to be mailed to all specialty societies and HCPAC organizations that have identified an interest in surveying.
August 3, 2010	Recommendations due to the AMA from specialty societies.
August 26-28, 2010	Five-year review workgroups meet and review recommendations.

September 13, 2010	Workgroup recommendations and consent calendars sent to the RUC.
September 30 – October 3, 2010	RUC meeting to review workgroup recommendations and consent calendars
October 31, 2010	RUC recommendations submitted to CMS.
November 2010-February 2011	CMS Review
March 2011	Notice of Proposed Rulemaking (NPRM) on Five-Year Review
November 2011	Final Rule on Five-Year Review
January 1, 2012	Implementation of new work relative value units.

RUC Chairman's Report

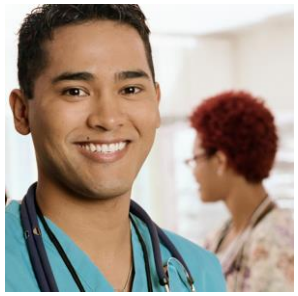
Jan 29 – Feb 1, 2009

Phoenix, AZ

AMA

TOGETHER WE ARE STRONGER



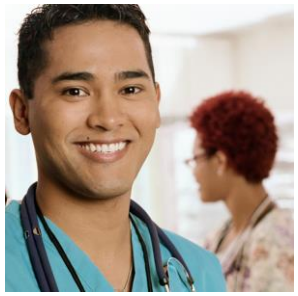



Procedural Issues

Advisors:

- Financial Disclosure Forms-must be on file prior to presentation – no forms are accepted at the meeting.
- Attestations of Survey data should be signed with or after the submission of the SOR. AMA had received statements from Advisors prior to submission of any recommendations
- Before the presentation of a new code, the Chairman will ask presenters to declare any conflicts

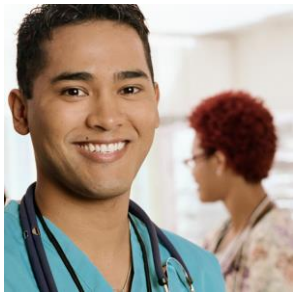


Procedural Issues

- October 2006 – The RUC reaffirmed that RUC advisors and presenters verbally disclose financial conflicts prior to presenting relative value recommendations
- The RUC also recommended that the RUC Chair ask RUC advisors and presenters to verbally disclose any travel expenses for the RUC meeting paid by an entity other than the specialty society



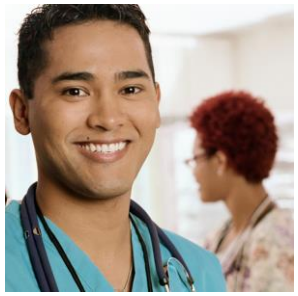



Procedural Issues

RUC Members:

- Before a presentation, any RUC member with a conflict will state their conflict and the Chair will rule on recusal.
- RUC members or alternates sitting at the table may not present or debate for their society

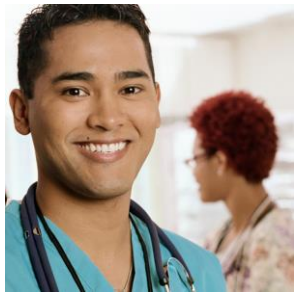


Procedural Issues

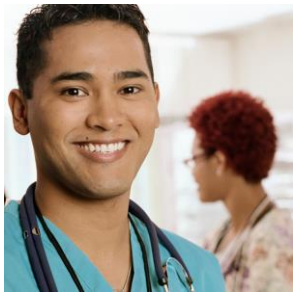
- For **new** codes, the Chairman will inquire if there is any discrepancy between submitted PE inputs and PE Subcommittee recommendations or PEAC standards.
- If the society has not accepted PE Subcommittee recommendations or PEAC conventions, the tab will be immediately referred to a Facilitation Committee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



Summary of Recommendation Form

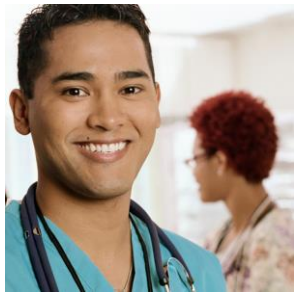
- Please note the new summary of recommendations forms
- The RUC should provide any feedback if sections of the summary are incorrect (pre-service times, modifier – 51, PLI crosswalk, etc.)
- RUC Members and Alternates should carefully review frequency information per new or revised code



RUC Meeting

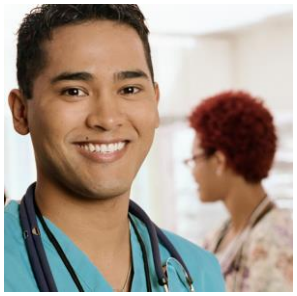
- **Cell phones!!!**



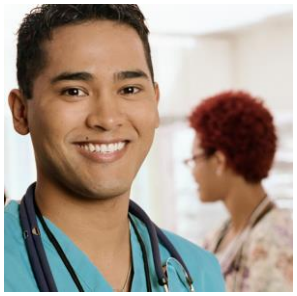
CMS Representatives

- Edith Hambrick, MD – CMS Medical Officer
- Whitney May – Deputy Director, Division of Practitioner Services
- Ken Simon, MD – CMS Medical Officer
- Pam West, DPT, MPH – Health Insurance Specialist



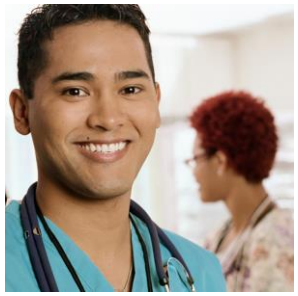
Medicare Contractor Medical Directors

- Charles Haley, MD



National Health Policy Forum Staff

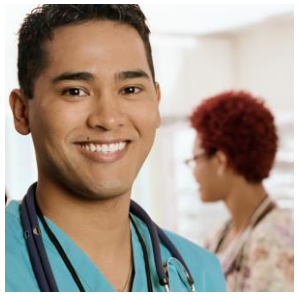
- Laura Dummit



Facilitation Committee #1

- Bibb Allen, MD (Chairman)
- Joel Bradley, Jr., MD
- Ron Burd, MD
- Thomas Cooper, MD
- Emily Hill, PA-C
- Peter Hollmann, MD
- J. Leonard Lichtenfeld, MD
- Charles Mick, MD
- Gregory Przybylski, MD
- Peter Smith, MD
- Samuel Smith, MD



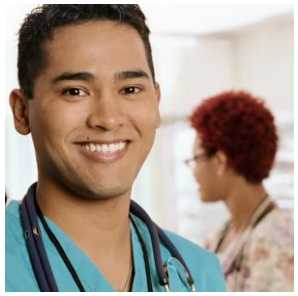
Facilitation Committee #2

Navigational Bronchoscopy Pre-Facilitation

Thursday, January 29, Noon -1:00 pm

- Gregory Kwasny, MD (Chairman)
- Michael Bishop, MD
- James Blankenship, MD
- Dale Blasier, MD
- Thomas Felger, MD
- Barbara Levy, MD
- William Mangold, Jr, MD
- Marc Raphaelson, MD
- Lloyd Smith, DPM
- Susan Spires, MD
- James Waldorf, MD

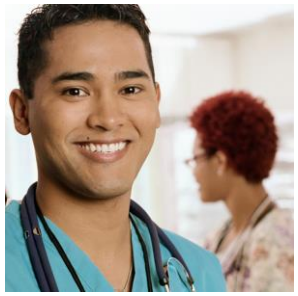


Facilitation Committee #3

- Maurits Wiersema, MD (Chairman)
- Katherine Bradley, PhD
- John Gage, MD
- David Hitzeman, DO
- Charles Koopmann, MD
- Brenda Lewis, MD
- Lawrence Martinelli, MD
- Bill Moran, MD
- Daniel Mark Siegel, MD
- Arthur Traugott, MD
- Robert Zwolak, MD

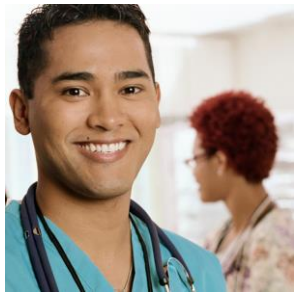


RUC Observers

- Debra Abel – American Academy of Audiology
- Margie Andreae – American Academy of Pediatrics
- Brett Baker – American College of Physicians
- Robert Barr – American Society of Neuroradiology
- Michael Bigby – American Academy of Dermatology
- Eileen Brewer, MD – Renal Physicians Association
- Neil Busis – American Academy of Neurology

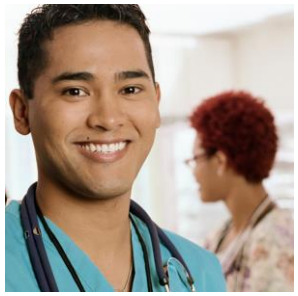


RUC Observers

- Scott Collins – American Academy of Dermatology
- Allan Desmond – American Speech Language Hearing Association
- Edward Eikman – Society of Nuclear Medicine
- Jennifer Frazier - American Society for Therapeutic Radiology and Oncology
- Emily Gardner – American College of Cardiology
- Denise Garris – American College of Cardiology
- Richard Gilbert, MD – American Urological Association
- John Goodson – American College of Physicians

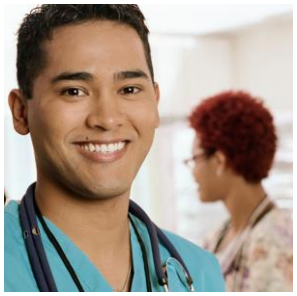


RUC Observers

- Robert Hall – American Association of Hip and Knee Surgeons
- David Han – Society for Vascular Surgery
- Zachary Hochstetler – Society of Nuclear Medicine
- Robert Jasak – American Academy of Orthopaedic Surgeons
- Robert Jones – American College of Cardiology
- Kendall Kodey – American College of Cardiology
- Carrie Kovar – American College of Cardiology
- Katie Kuechemneister – American Academy of Neurology
- Alex Little, MD – Society of Thoracic Surgeons

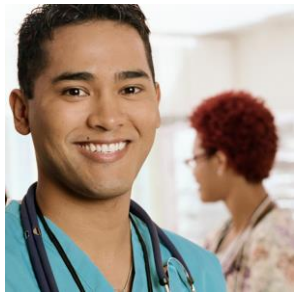


RUC Observers

- Kenneth McKusick, MD – Society of Nuclear Medicine
- Erika Miller – American College of Physicians
- Lisa Miller-Jones – American College of Surgeons
- Dewan Naakesh – American Psychiatric Association
- Gerald Neidzwiecki, MD – Society of Interventional Radiology
- Dee Nikjeh – American Speech Language Hearing Association
- Vinita Ollapally – American College of Surgeons

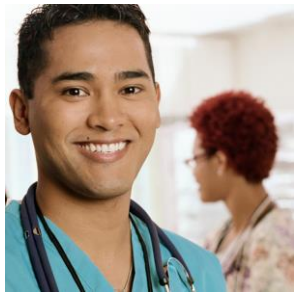


RUC Observers

- Debbie Ramsburg – Society of Interventional Radiology
- John Ratliff, MD – American Association of Neurological Surgeons
- David Regan, MD – American Society of Clinical Oncology
- Paul Rudolf, MD, JD – American Geriatrics Society
- Matthew Sideman, MD – Society for Vascular Surgery
- Ezequiel Silva, MD – Society of Interventional Radiology
- Maurine Spillman-Dennis – American College of Radiology

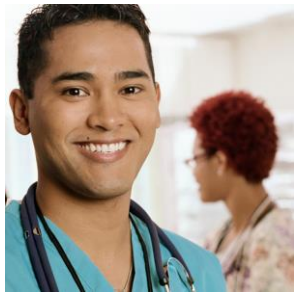


RUC Observers

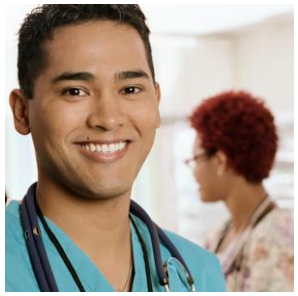
- James Startzell, MD – American Association of Oral and Maxillofacial Surgeons
- Michael Sutherland – Society for Vascular Surgery
- Tim Tillo – American Podiatric Medical Association
- William van Decker – American College of Cardiology
- Edward Vates, MD – American Association of Neurological Surgeons
- Allison Waxler – North American Spine Society
- Duane Whitaker, MD – American Academy of Dermatology



RUC Observers

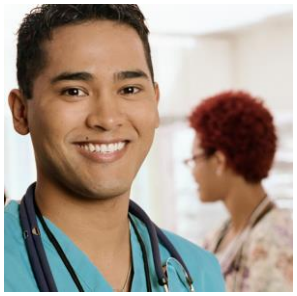
- Joanne Willer – American Academy of Orthopaedic Surgery
- Kadyn Williams – American Academy of Audiology
- Pamela Woodard – American College of Radiology
- Jennifer Young – American Association of Clinical Endocrinologists



Welcome New RUC Members

- Brenda Lewis, DO – American Society of Anesthesiologists



Departing RUC Members

- James Anthony, MD – American Academy of Neurology
- Thomas Felger, MD – American Academy of Family Physicians


AMA
AMERICAN
MEDICAL
ASSOCIATION

Physician Practice Information Survey

RUC Meeting – January 29, 2009

AMA

TOGETHER WE ARE STRONGER




Survey Launched in 1st Qtr 2008

- **Dmr**kynetec mailed survey packets in three waves from late January through late March.
- More than 50,000 physicians received the survey packet.
- All physicians should have received at least ten phone calls. Some physicians have received as many as 15 calls.
- Most physicians chose to complete the survey on web – phone, mail, fax, web were all allowed




Expectations

- 1,000 new completes by April 30.
- 3,000 completed surveys by August 31
- 4,000 completed surveys by October 31
- 100 completes per specialty (5,000 overall) by December 31, 2008
- PE/Hour computations to be delivered to CMS by March 31, 2009.




Responses – January 29

- More than 7,300 physicians have participated
- Nearly every specialty had in excess of 100 physicians responding to survey
- 611 useable completes from 2007 Gallup effort.
- 4,431 Dmrkynetec New Completes
- Total of 5,042 Completed Surveys (according to survey firm)




Next Steps – 1st Quarter 2009

- Dmrkynetec to send AMA data for all MD/DO respondents by early February
- Dmrkynetec to send Lewin data for all non-MD/DO respondents by early February
- Data to be cleaned and analyzed by AMA economists and Lewin to determine level of completeness
- Practice Expense/Physician Hours (PE/Hour) will be computed on a specialty level by March 31, 2009 for delivery to CMS



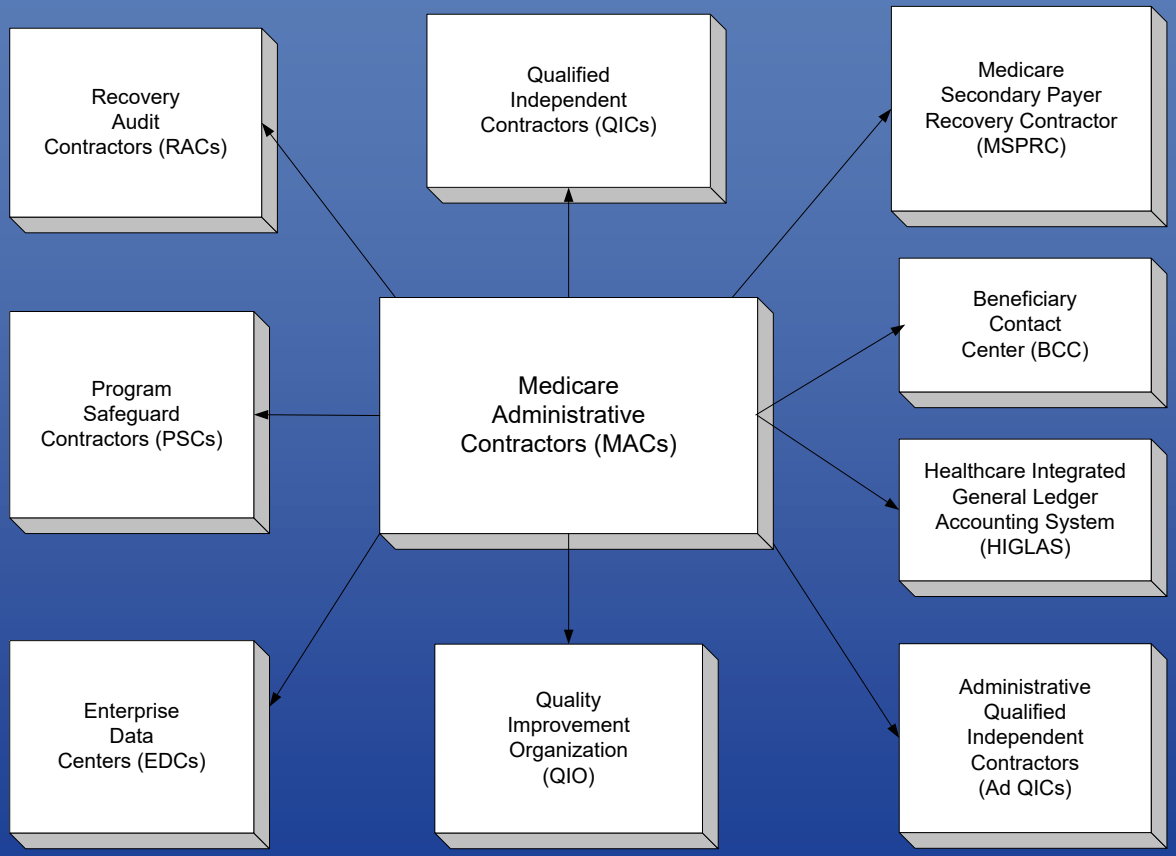

Next Steps – 2nd Quarter 2009

- AMA will work with CMS, Lewin, and relevant specialty societies if any further analysis is required.
- AMA will prepare detailed reports for each of the specialties who participated in the survey effort.
- A summary report will be prepared for the April 23-26 RUC meeting.
- CMS to release NPRM in Summer 2009

Contracting Reform

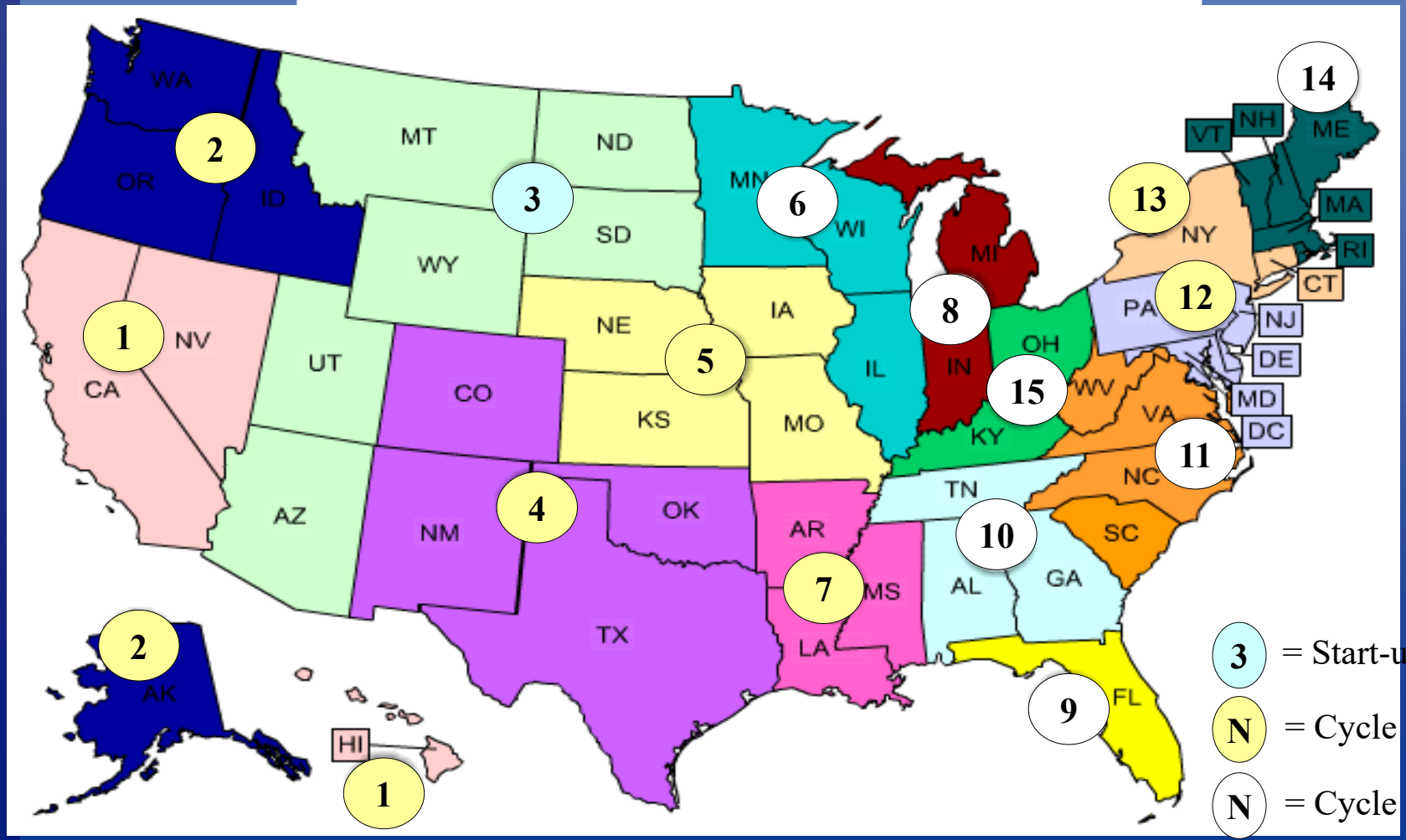
- Started in early 1990's with the development of specialty contractors for DME and Home Health Claims.
- HIPAA legislation created "Payment Safeguard Contractors" for fraud investigation.
- Accelerated with MMA (2003).
- CMS is moving away from single multifunction contractor to many single function contractors.

Medicare Functional Environment



Medicare Contracting Reform

New A/B MAC Jurisdictions



Medicare Contracting Reform

- **Startup Cycle:**
  - A/B MAC Jurisdiction 3 awarded to Noridian
- **Cycle One:**
  - A/B MAC Jurisdiction 4 awarded to TrailBlazer
  - A/B MAC Jurisdiction 5 awarded to WPS
  - A/B MAC Jurisdiction 1 awarded to Palmetto
  - A/B MAC Jurisdiction 12 awarded to Highmark
  - A/B MAC Jurisdiction 13 awarded to NGS
- Cycle One – Re-Bids
  - A/B MAC Jurisdiction 2 (NHIC) (4/1/2009?)
  - A/B MAC Jurisdiction J7 (Pinnacle) (2/1/2009?)
- **Cycle Two:**
  - **A/B MAC Jurisdiction 9 awarded to First Coast**
  - Awards for the rest may be made by July 2009

Medicare Contracting Reform

- **Cycle Two:**
  - **A/B MAC Jurisdiction 9 awarded to First Coast**
  - **A/B MAC Jurisdiction 14 awarded to NHIC**
- **Most recent awards**
  - A/B MAC Jurisdiction 6 awarded to Noridian
  - A/B MAC Jurisdiction 8 awarded to NGS
  - A/B MAC Jurisdiction 10 awarded to Cahaba
  - A/B MAC Jurisdiction 11 awarded to Palmetto
  - A/B MAC Jurisdiction 15 awarded to Highmark

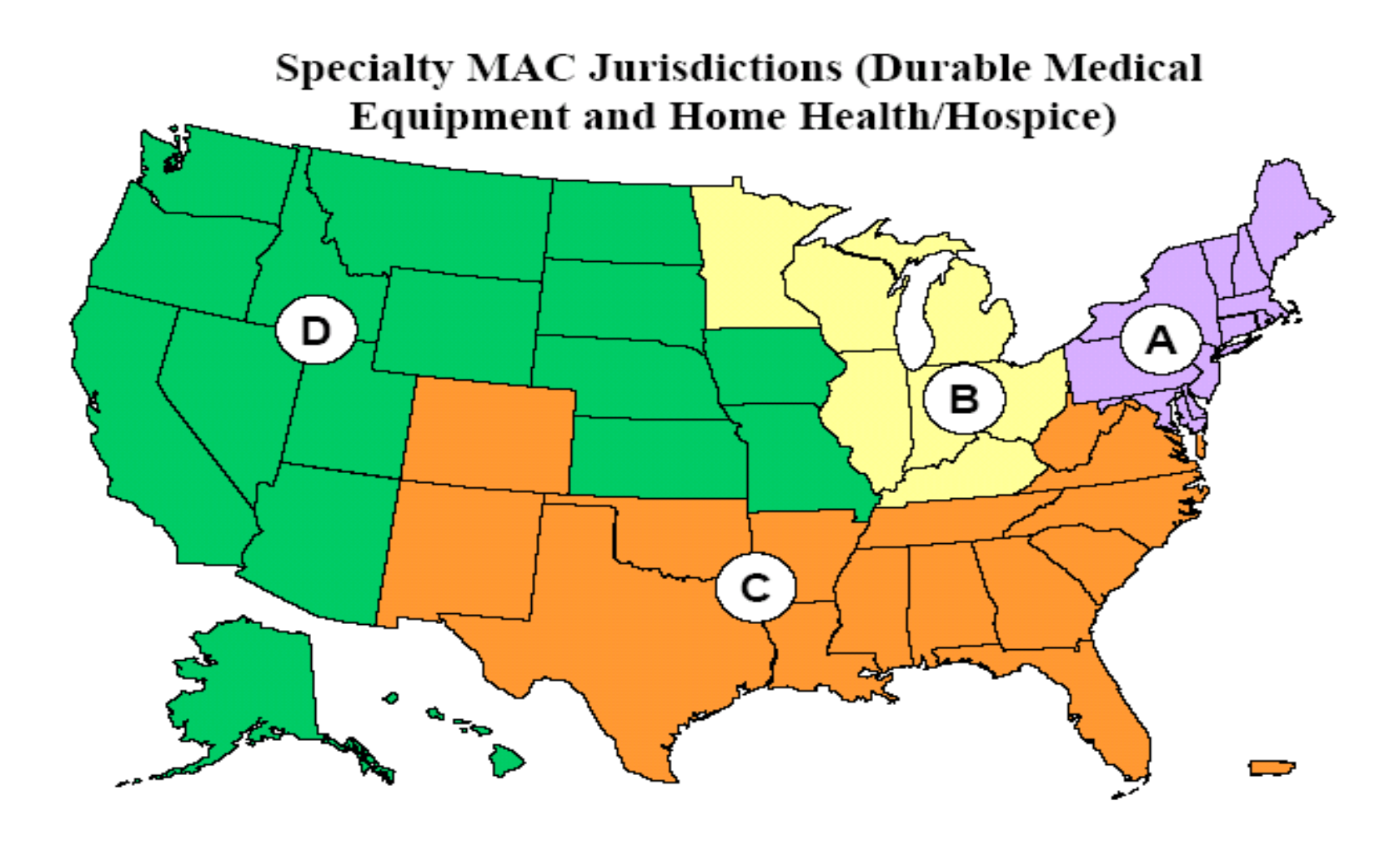
Semi-Final MAC Contractors

• Noridian	J3,	J6D,	JD
• NHIC	J2,	J14A,	JA
• NGS	J8,	J13,	JB
• Palmetto	J1,	J11C	
• Highmark	J12,	J15B	
• TrailBlazer	J4		
• WPS	J5		
• Pinnacle	J7		
• First Coast	J9		
• Cahaba	J10		
• Cigna			JC

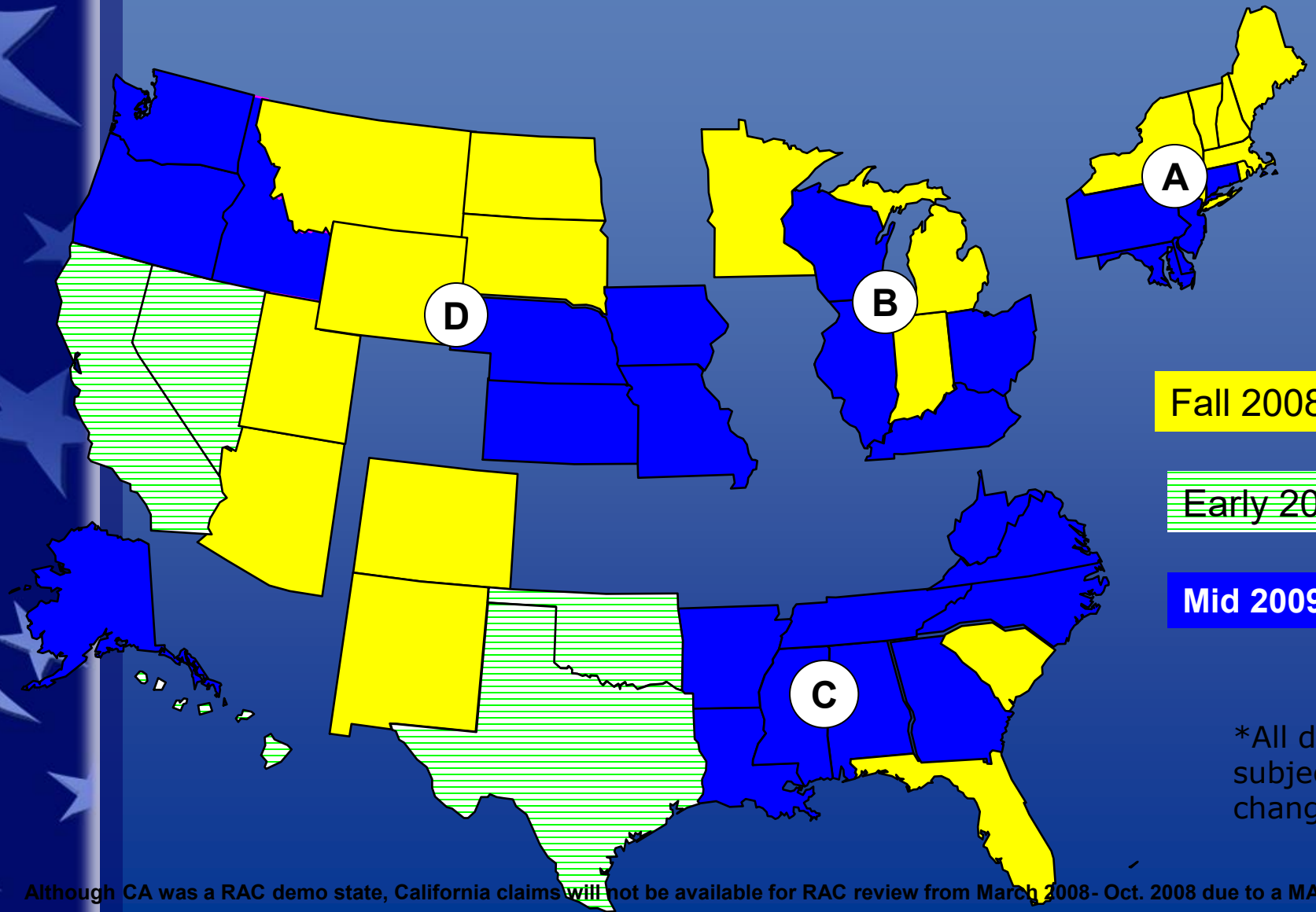
System Changes

- All contractors now use MCS (“Part B” system) and FISS (“Part A” system).
- HIGLAS transitions underway.
- Transitions to new EDCs (2006-2008).
- MSP Transition completed.
- NPI Implementation Complete.
- Transitions to MACs (2006-2010).
- ICD10 after 2010.

Medicare Contracting Reform



Recovery Audit Contractors



Fall 2008*

Early 2009*

Mid 2009*

*All dates are subject to change

Although CA was a RAC demo state, California claims will not be available for RAC review from March 2008- Oct. 2008 due to a MAC transition

Inpatient vs Outpatient: Part B

- Place of service data in RUC database represents place of service as billed on the physician claim.
- In Part B, Facility vs Non-facility place of service has payment implications;
  - However, Inpatient hospital vs outpatient hospital (21 vs 22) does not have Part B payment implications.

Inpatient vs Outpatient: Part A

- Inpatient = True Part A; Outpatient = Part B
  - Different patient liability.
- Decision to admit to inpatient status is determined by physician order.
- Hospital UR Committee may subsequently decide to bill stay as outpatient:
  - Billed with Condition code 44;
  - Changes beneficiary liability;
    - Changes from “Part A” to “Part B”;
  - Required to notify “a” physician;
    - Not required to notify admitting physician of change in status.
- Special payment rules for outpatient observation.

The End

RUC Recommended Physician Time from October 2008 and February 2009 for CPT Cycle 2010

CPT Code	Tracking Code	RUC Meeting Date	Pre Service Evaluation Time	Pre Service Dress Scrub and Wait Time	Pre Service Positioning Time	Intra Service Time	Immediate Post Service	99291	99231	99232	99233	99238	99212	99213	99214	Total Time
21015	P5	2/1/2009	40	20	8	75	30					0.5	1	3		277
21557	P11	2/1/2009	40	20	12	113	30		1	1		1.0	1	3		398
21930	P13	2/1/2009	14	10	18	45	20					0.5	1	1		165
21935	P17	2/1/2009	40	20	20	120	25		1	1		1.0	1	3		408
22900	P21	2/1/2009	33	15	3	60	20		1			1.0	2	1		244
23077	P29	2/1/2009	40	20	20	140	30		1	1		1.0	1	3		433
23200	P31	2/1/2009	40	20	12	155	30		1	2		1.0	1	2	1	497
23210	P32	2/1/2009	40	20	20	210	30		1	2		1.0	1	2	1	560
23220	P33	2/1/2009	40	20	12	240	30		2	2		1.0	1	2	1	602
24150	P40	2/1/2009	40	20	12	180	30		2	1		1.0	1	2	1	502
24152	P41	2/1/2009	33	15	12	150	30		1	1		1.0	1	2	1	440
25077	P46	2/1/2009	40	20	12	100	30		1			1.0	1	3		345
25170	P48	2/1/2009	33	15	12	180	30		1	1		1.0	1	2	1	470
26117	P53	2/1/2009	40	20	12	75	20					0.5	1	3		271
26250	P55	2/1/2009	23	15	10	120	25		1			1.0	1	2	1	353
26260	P56	2/1/2009	23	15	10	90	20					0.5	1	1	1	256
26262	P57	2/1/2009	14	10	10	60	20					0.5	1	1	1	212
27075	P64	2/1/2009	40	20	3	240	30		2	3		1.0	1	2	1	633
27076	P65	2/1/2009	40	20	20	360	40		3	4		1.0	1	2	1	840
27077	P66	2/1/2009	40	20	20	400	45		4	4		1.0	1	2	1	905
27078	P67	2/1/2009	40	20	20	240	45		2	3		1.0	1	2	1	665
27365	P74	2/1/2009	40	20	3	240	30		2	3		1.0	1	2	1	633
27615	P75	2/1/2009	40	20	23	120	30		1	1		1.0	1	3		416
27645	P81	2/1/2009	40	20	3	200	30		2	2		1.0	1	2	1	553
27646	P82	2/1/2009	40	20	20	180	40		1	2		1.0	1	2	1	540
27647	P83	2/1/2009	43	15	20	144	30		1	2		1.0	1	1	1	469
28046	P84	2/1/2009	33	15	8	90	25		2			1.0	1	3		334
28120		2/1/2009	33	15	10	50	20		1			1.0	3	2		280
28122		2/1/2009	33	15	10	50	20		1			1.0	2	2		264
28171	P90	2/1/2009	43	15	20	120	30		1			1.0	1	1	1	365
28173	P91	2/1/2009	19	5	3	110	30		1			1.0	1	1	1	304
28175	P92	2/1/2009	19	5	3	60	20					0.5	1	1	1	205
28725		2/1/2009	45	15	10	90	20		1			1.0	2	3		339
28730		2/1/2009	45	15	10	100	20		1			1.0	2	3		349
36825		2/1/2009	40	20	10	120	30		1			1.0	1	2		340
42415		2/1/2009	40	20	12	150	20					1.0	1	2		342
42420		2/1/2009	40	20	12	180	20		1	1		1.0	1	2		432
49507		2/1/2009	40	20	3	70	30		1			1.0	1	1		260
49521		2/1/2009	40	20	3	90	30		1			1.0	1	1		280
49587		2/1/2009	40	20	3	60	30		1			1.0	1	1		250
55873		2/1/2009	33	15	8	100	30					0.5		3		274
92597		2/1/2009	7			40	13									60
92610		2/1/2009	7			35	10									52
92611		2/1/2009	7			30	10									47
210X1	P1	2/1/2009	13		6	30	10						1	1		98
210X2	P2	2/1/2009	19	5	6	45	15					0.5	1	1		148
210X3	P3	2/1/2009	33	15	8	45	15					0.5	1	1		174
210X4	P4	2/1/2009	33	15	8	60	20					0.5	1	2		217
210X5	P6	2/1/2009	40	20	8	100	30		1	1		1.0	1	2	1	398
215X0	P7	2/1/2009	19	5	6	35	15					0.5	1	1		138
215X1	P8	2/1/2009	33	15	3	60	25					0.5	1	1		194
215X2	P9	2/1/2009	33	15	20	60	25					0.5	1	2		234
215X3	P10	2/1/2009	40	20	20	90	30		1			1.0	1	2		320
219X1	P14	2/1/2009	33	15	20	60	20					0.5	1	1		206
219X2	P15	2/1/2009	33	15	20	75	20		1			1.0	2	1		276
219X3	P16	2/1/2009	40	20	20	90	25		1			1.0	1	2		315
219X4	P18	2/1/2009	40	20	20	160	30		1	2		1.0	1	2	1	510
229X0	P19	2/1/2009	14	10	1	45	20					0.5	1	1		148
229X1	P20	2/1/2009	33	15	3	50	20					0.5	1	1		179
229X2	P22	2/1/2009	33	15	3	90	30		1			1.0	2	1		284
229X3	P23	2/1/2009	40	20	3	120	30		1	1		1.0	1	3		396
229X4	P24	2/1/2009	40	20	3	150	30		2	1		1.0	1	2	1	463
230X0	P25	2/1/2009	14	10	10	30	20					0.5	1	1		142
230X1	P26	2/1/2009	33	15	20	45	20					0.5	1	1		191
230X2	P27	2/1/2009	33	15	12	60	20					0.5	1	2		221
230X3	P28	2/1/2009	33	15	12	75	30		1			1.0	1	2		285
230X4	P30	2/1/2009	40	20	20	180	30		1	1		1.0	1	2	1	490
240X0	P34	2/1/2009	14	10	10	30	20					0.5	1	1		142

RUC Recommended Physician Time from October 2008 and February 2009 for CPT Cycle 2010																
CPT Code	Tracking Code	RUC Meeting Date	Pre Service Evaluation Time	Pre Service Dress Scrub and Wait Time	Pre Service Positioning Time	Intra Service Time	Immediate Post Service	99291	99231	99232	99233	99238	99212	99213	99214	Total Time
240X1	P35	2/1/2009	33	15	12	45	20					0.5	1	1		183
240X2	P36	2/1/2009	33	15	20	60	20					0.5	1	2		229
240X3	P37	2/1/2009	33	15	20	75	20		1			1.0	1	2		283
240X4	P38	2/1/2009	40	20	12	120	30		1	1		1.0	1	3		405
240X5	P39	2/1/2009	40	20	12	150	30		2	1		1.0	1	2	1	472
250X0	P42	2/1/2009	14	10	10	30	15					0.5	1	1		137
250X1	P43	2/1/2009	33	15	12	45	15					0.5	1	1		178
250X2	P44	2/1/2009	33	15	12	45	20					0.5	1	2		206
250X3	P45	2/1/2009	33	15	12	60	20					0.5	1	2		221
250X4	P47	2/1/2009	40	20	12	120	30		1	1		1.0	1	2	1	422
261X0	P49	2/1/2009	14	10	10	30	15					0.5	1	1		137
261X1	P50	2/1/2009	33	15	12	40	15					0.5	1	1		173
261X2	P51	2/1/2009	33	15	12	45	15					0.5	1	2		201
261X3	P52	2/1/2009	33	15	12	58	15					0.5	1	2		214
261X4	P54	2/1/2009	40	20	12	100	20		1			1.0	2	2	1	368
270X0	P58	2/1/2009	14	10	18	40	20					0.5	1	1		160
270X1	P59	2/1/2009	33	15	20	60	20					0.5	1	1		206
270X2	P60	2/1/2009	40	20	20	75	20		1			1.0	2	1		288
270X3	P61	2/1/2009	40	20	20	90	30		1			1.0	1	2		320
270X4	P62	2/1/2009	40	20	3	180	30		1	2		1.0	1	3		496
270X5	P63	2/1/2009	40	20	3	220	45		3	2		1.0	1	2	1	608
273X0	P68	2/1/2009	14	10	8	30	20					0.5	1	1		140
273X1	P69	2/1/2009	33	15	10	45	20					0.5	1	1		181
273X2	P70	2/1/2009	33	15	20	60	20		1			1.0	2	1		261
273X3	P71	2/1/2009	40	20	20	90	20		1			1.0	1	2		310
273X4	P72	2/1/2009	40	20	20	120	30		1	1		1.0	1	3		413
273X5	P73	2/1/2009	40	20	20	180	30		2	2		1.0	1	2	1	550
2761X	P76	2/1/2009	40	20	23	150	30		1	1		1.0	1	2	1	463
276X0	P77	2/1/2009	14	10	10	30	15					0.5	1	1		137
276X1	P78	2/1/2009	33	15	12	45	20					0.5	1	1		183
276X2	P79	2/1/2009	33	15	23	60	20					0.5	2	1		225
276X3	P80	2/1/2009	33	15	23	70	20		1			1.0	1	2		281
2804X	P85	2/1/2009	40	20	8	120	25		1	1		1.0	1	2	1	413
280X0	P86	2/1/2009	19	5	6	30	20					0.5	1	1		138
280X1	P87	2/1/2009	19	5	6	45	20					0.5	1	1		153
280X2	P88	2/1/2009	19	5	6	45	20					0.5	2	1		169
280X3	P89	2/1/2009	33	15	8	60	20					0.5	1	2		217
316X1	E1	2/1/2009				60										60
3255X	A1	10/1/2008	13	6	1	15	12					0.5	1			82
3377X1	B1	10/1/2008	40	20	3	300	60	2	1	1	3	1.0			1	866
3377X2	B2	10/1/2008	40	20	3	360	60	2	1	1	3	1.0			1	926
451X1	G1	2/1/2009	33	15	15	45	20					0.5	1	2		209
451X2	G2	2/1/2009	40	20	15	75	20		1			1.0	1	2		290
5385X	H1	2/1/2009	7			15	10									32
574XX	C1	10/1/2008	40	20	3	110	40			1		1.0		3		360
7557X1	K1	2/1/2009	5			10	5									20
7557X2	K2	2/1/2009	10			20	10									40
7557X3	K3	2/1/2009	15			30	15									60
7557X4	K4	2/1/2009	10			30	10									50
7733X	J1	2/1/2009				115										115
784X1		2/1/2009	10			15	10									35
784X2		2/1/2009	10			20	10									40
784X3		2/1/2009	5			10	5									20
784X4		2/1/2009	5			15	5									25
9590X1	M1	2/1/2009				5										5