

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE MEETING

The Stouffer Riviere Hotel
Chicago, Illinois
June 25 - 27, 1993

MINUTES

[I HAVE MADE SOME REVISIONS. MAIN CORRECTIONS STILL TO BE MADE ARE THAT THERE IS STILL NO MENTION OF THE FACILITATION COMMITTEE FOR THE NEONATAL INTENSIVE CARE CODES NOR THE FACILITATION COMMITTEE THAT SHERRY SAT IN ON. MY OTHER COMMENTS ARE NOTED IN CAPS WITH BRACKETS THROUGHOUT THE DOCUMENT LIKE THIS NOTE]

Call to Order

Doctor Rodkey called the meeting to order at 8:00 a.m. Friday, June 25. The following RUC members and alternates were in attendance:

Grant V. Rodkey, MD	David L. McCaffree, MD
Robert K. Anzinger, MD	Kenneth A. McKusick, MD
Robert Berenson, MD	James M. Moorefield, MD
Robert Florin, MD *	George E. Miller, Jr., MD *
John O. Gage, MD	L. Charles Novak, MD
Timothy Gardner, MD	Eugene S. Ogrod II, MD
William Gee, MD	Bergein F. Overholt, MD
Tracy R. Gordy, MD	Byron Pevehouse, MD
Michael Graham, MD	William Rich, MD *
W. Benson Harer, Jr., MD	Paul Schnur, MD *
Kay K. Hanley, MD	Ray E. Stowers, DO
James E. Hayes, MD *	John P. Tooker, MD *
George F. Kwass, MD	Richard Tuck, MD
J. Leonard Lichtenfeld, MD *	John Tudor, Jr., MD
Michael D. Maves, MD	William L. Winters, Jr., MD

*RUC Alternate

Doctor Rodkey introduced Alfred Taricco, MD, who was attending as an observer from the International Association of Industrial Accident Boards and Commissions (IAIABC), and Samuel Shekar, MD, of the Health Care Financing Administration, who joined Marc Stone, MD JD, as an observer from HCFA. Doctor Rodkey announced that Donald T. Lewers, MD, former AMA representative to the RUC, had been elected to the AMA Board of Trustees. Doctor Hanley, former alternate RUC member for the AMA, will replace him as the AMA's RUC member. She will also serve as Vice Chair.

Doctor Rodkey commented that 121 people were attending the meeting, which was scheduled to review a large number of issues. He congratulated the specialty societies and the AMA staff for the prodigious amount of work they had done to prepare for the meeting.

Approval of April 30-May 2 Minutes [Tab 1]

The minutes of the last meeting were amended. A section on page 6 dealing with psychotherapy codes should read: "extended to 70 minutes." **A motion was made and approved to accept the minutes as amended.**

Relative Value Recommendations:

1. Prolonged Physician Services [Tab 4]

Tracking Numbers: TT1-TT7

Presentation: Walter L. Larimore, MD; Laurence Wellikson, MD

American Academy of Family Physicians

American Society of Internal Medicine

American College of Obstetricians and Gynecologists

Prolonged physician service codes are to be used when a physician provides prolonged service to a patient above and beyond what is usually required of that service in either the inpatient or outpatient setting. The RUC noted that the addition of these codes fills a void in the current coding system, since there is presently no way to report evaluation and management services that extend beyond the service described by the Level V codes. The RUC also concluded that, given appropriate coverage and payment policies, the addition of these codes by CPT, particularly the outpatient codes, would help ensure that services were provided in the most appropriate setting and reduce the incidence of more costly emergency room visits and hospital admissions.

The recommendations are derived from a survey primarily of family physicians and internists, as well as a small group process involving extensive assessment of the relationship between the work involved in the new codes and that involved in the key reference services, including each of the four dimensions of work. The RUC's discussion of the relative value recommendations focused on various aspects of the time factor involved in the prolonged service codes and the relationship between time and work. The idea that the time spent by the physician is not necessarily continuous was taken into consideration by the RUC and it was clear that only the actual face-to-face physician time for the services described by 99354-99357 would be counted in using these codes.

2. Care Plan Oversight [Tab 5]

Tracking Numbers: VV1-VV2

Presentation: Laurence Wellikson, MD; Walter Larimore, MD

American Society of Internal Medicine

American Academy of Family Physicians

The two new codes for care plan oversight reflect physician case management services involving physician supervision of patients under care of home health agencies, hospice or nursing facility patients. These services include development and periodic revision of care plans and telephone communications with other health care professionals involved in the patient's care.

The RUC's discussion of these codes recognized that they describe a significant physician work activity which is not currently compensated by Medicare. The recommendations were based on a survey of internists and family physicians, and the RUC accepted the rationales presented by the specialties. The stress involved in care plan oversight services is typically higher than a level 4 or 5 office visit (99244 or 99215), since the physician must often make complex care plan decisions based upon information

obtained from non-physician health professionals without directly examining the patient. The RUC found that the recommendations accurately reflected the intensity and complexity of the work involved in the care plan oversight services. The Committee noted that many people who are very ill, including some AIDS patients, elderly, disabled, and rural patients, cannot get to a physician's office, and that the number of people whose care is being managed but who are not visiting the physician directly is increasing. For many of these types of patients, the care plan oversight is provided when face-to-face encounters are either unnecessary or difficult to arrange.

The RUC also concluded that the codes were likely to result in cost savings for Medicare because, like the prolonged physician service codes, they increase the likelihood that care will be provided in the most appropriate and cost-effective setting rather than keeping patients hospitalized longer than would otherwise be necessary. For example, premature infants may be sent home earlier or elderly patients may remain at home rather than entering a nursing facility or hospital.

3. Hospital Observation Services [Tab 6]

Tracking Numbers: UU1

Presentation: Larry P. Griffin, MD

American College of Obstetricians and Gynecologists

The addition of a separate code for observation care discharge management may be used by the physician to report all services provided to a patient on discharge from "observation status" on any day other than the initial. The RUC agreed that the work involved in discharging a patient from "observation status" is very similar to the work involved in discharging a hospital inpatient. The RUC treated this code more like a revised code than a new code, since the service was previously included in code 99238. The RUC thus recommends no change from the established value for code 99238.

4. Delivery, Antepartum, and Postpartum Care [Tab 7]

Tracking Numbers: WW1-WW4

Presentation: Larry P. Griffin, MD; Walter Larimore, MD

American College of Obstetricians and Gynecologists

American Academy of Family Physicians

Discussion focused on the specialty's concerns that the relative work values for obstetric codes were not based upon valid information obtained from surveys. Dr. Griffin said that obstetrics services were "grievously ignored" in the Hsiao study. It was suggested that a survey be conducted for all of the obstetric codes -- including new, revised, and existing codes -- with the aim of eliminating the current anomalies. The RUC responded by expressing its concern that surveying for existing codes that were neither new nor revised and that had existing values was beyond the RUC's current scope, but referred this issue to the Research Subcommittee as mentioned at the conclusion of these minutes.

The RUC proceeded to evaluate the recommendations for the new codes assuming no change in the existing values for the existing codes. The new codes allow physicians to receive partial payment for treating patients who initiate care for a global obstetrical service but who transfer their care to another physician. For example, if a patient delivers after moving to a new area, the new codes allow the physician who provided the initial prenatal care to submit a separate claim. An EM code would be used instead of an antepartum care code if the physician saw the patient fewer than four times.

The RUC accepted the specialties' rationale that the work of the new code 59425 was equivalent to an initial visit coded as a 99204 and four subsequent visits coded as a 99213. Likewise, the new code 59426 is considered equivalent in work to one 99204 service and nine visits coded as 99213.

The relative value recommendations for new codes 59409 and 59514 are only slightly less than those assigned to codes 59410 and 59515 because of the additional work involved in delivering new patients compared with those whom the physician has managed during the prenatal period. In these situations, the physician must elicit a history from a woman in active labor, perform a comprehensive maternal-fetal evaluation, and make medical decisions about care for the mother and baby in an environment of great uncertainty. After discussion between CPT and HCFA staff, the RUC adopted these values with the understanding that neither inpatient nor outpatient postpartum care was included in the CPT descriptors for these new codes.

5. Pelvic Lymph Node Dissection [Tab 8]

Tracking Numbers: Z1-Z4

Presentation: Larry P. Griffin, MD

American College of Obstetricians and Gynecologists

American Urological Association

The first code in the series for pelvic lymph node dissection was essentially an editorial change. The code was revised to specify the surface where the biopsy is performed. However, this code is very similar to 49301, which has a higher value, and either one could be used to report the service. The RUC felt, however, that 49301 represents a broader code, which could encompass biopsy of the liver, for example, while 56305 is narrower in its description. The RUC recommends that the current established value by HCFA's refinement process be maintained.

The RUC compared the laparoscopic codes for pelvic lymphadenectomy with their open procedure counterparts. The extent of dissection of the lymph node tissue is the same for both the laparoscopic and open procedures. The intraservice work involved in the laparoscopic procedures requires greater technical expertise and higher intensity than the open procedure, although the postoperative care is less. The RUC accepted the specialty recommendation that the new codes 56311 and 56312 be valued at a level somewhat lower than the corresponding open procedures to reflect the shorter global periods and reduced postoperative care.

The RUC referred new code 56313 back to the gynecologists for further study because this procedure is extremely rare and insufficient data were available to make a valid recommendation at this time.

6. Colposcopy [Tab 9]

Tracking Number: XX1

Presentation: Larry P. Griffin, MD

American College of Obstetricians and Gynecologists

The RUC evaluated the frequency with which colposcopy would be performed with biopsy or endoscopic curettage or both, and concluded that the service would usually include both procedures. The building block approach of adding 50% of the work of code 57505 to the value of 57452 therefore appeared to be appropriate, particularly since the base code was 57452 (1.01 RVW) rather than the current descriptor and value for 57454 (1.30 RVW).

7. Neonatal Intensive Care [Tab 10]

Tracking Numbers: H1-H3

Presentation: James Lemons, MD; Andrew Costarino, MD

American Academy of Pediatrics

Society of Critical Care Medicine

The RUC's evaluation of the relative value recommendations for neonatal intensive care focused on the critical nature of the care described by the CPT descriptors and the vignettes developed by the neonatologists. Questions were raised about whether these codes could be used for babies in Level II nurseries or whether they could only be used for babies in Level III nurseries. Because the codes describe either premature or critically ill term babies requiring cardiopulmonary monitoring and support including ventilation or CPAP, surfactant administration, pharmacologic control of the circulatory system, intravascular fluid administration, and other services, the RUC concluded that not all Level II nurseries would have the capacity to provide this care but that some would.

Questions were also raised about how much time during a 24-hour period would be spent by the physician in providing services that are equivalent to critical care and whether that care was truly equivalent to critical care. The RUC's recommendations were based on the results of a survey of neonatologists, and the RUC concluded that the critical care codes, subsequent hospital care codes, and the procedures bundled into the neonatal intensive care codes were all appropriate key reference services. The lowest level of care, for a critically ill and stable neonate who is still intubated and still requires invasive cardiopulmonary monitoring, which is described by code 99297, is approximately equivalent to 3.5 Level III hospital visits. Code 99296, for the unstable neonate whose condition is changing almost minute-to-minute, involves nearly twice the work of the 99297 over the same 24-hour period. Initial neonatal intensive care (99295) is nearly twice the work of the subsequent care for the unstable baby, and is equivalent to nearly 5 hours of critical care. Moreover, if claims were submitted for separately providing each of the procedures bundled into the codes as well as the total evaluation and management services over the 24-hour periods, it appeared likely that the neonatologists' total claims would be greater than or at least equal to the recommended relative values.

8. ECMO [Tab 11]

Tracking Number: FF1-FF2

Presentation: Arvin I. Philippart, MD

American Pediatric Surgical Association

Society of Critical Care Medicine

Extracorporeal Membrane Oxygenation (ECMO) technology is the use of specific cardiopulmonary bypass technology utilizing a silicone membrane oxygenator for gas exchange and roller pump for maintenance and perfusion. Patients who are on cardiopulmonary bypass for days require prolonged intervals at the bedside by the physician. In the majority of ECMO centers, pediatric surgeons provide surgical procedures and management in the first 24 hours of care, and critical care personnel provide subsequent care. In order to maintain that medical/surgical separation, the survey added the decannulation procedure at the end of an ECMO run to the work of the first 24 hours in order to keep within the two codes recommended and to simplify the separation of work.

The RUC recommendations are based on a survey of 44 pediatric surgeons and critical care physicians. The response rate is notable as there are only 80 programs in the United States providing services to less than 1,000 patients per year. The care provided to these patients is very complex and requires a great amount of skill as there is a high risk of mortality (90%) and complications like cerebral hemorrhage. The amount of physician time included in the initial 24 hours of ECMO was evaluated by the RUC and

determined to include more than two hours of operative time and 6.5 hours of critical care, however, physician availability is required for the entire 24 hour period. Each subsequent 24 hour of care requires approximately 4 hours of the physician at the bedside.

9. Anal Repair [Tab 12]

Tracking Numbers: AB1-AB4

Presentation: Arvin I. Philippart, MD

American Pediatric Surgical Association

Congenital cloacal anomalies requiring the procedures described by the new codes for anal repair are very rare, occurring in less than 500 babies per year. The diagnostic assessment, operative planning, execution of the procedure, and postoperative management are as complex as any developmental anomaly in pediatric surgery with the exception of Siamese twins. The three codes represent progressively incremental severity of the anomaly and, therefore, progressively incremental work to develop three separate perineal orifices. The incremental difficulties are based on the relative presence or absence of local tissues for reconstruction. The entire process must occur in a single operative event of significant magnitude in order to create optimal results.

10. Orthopaedic Trauma [Tab 13]

Tracking Numbers: C2-C3

Presentation: Alan H. Morris, MD

American Academy of Orthopaedic Surgeons

These two additions to the orthopaedic trauma codes in CPT complete the extensive revisions made to this section last year. The recommendations are based on the results of a survey of orthopaedic surgeons using the standard RUC survey instrument. The RUC concluded that new code 24566 involves about 81% of the work of the key reference service code 24538 and new code 24582 involves about 88% of the work of this same reference procedure. The RUC also noted that the cast is included in the global fee whereas x-rays are billed separately.

11. Peripheral Vascular Surgery [Tab 14]

Tracking Numbers: AV1-AV11

Presentation: Norman R. Hertzner, MD

The Society for Vascular Surgery

The International Society for Cardiovascular Surgery

The RUC's recommendations for the new and revised codes for peripheral vascular surgery are principally based on the results of a survey of vascular surgeons. In addition to the survey results, the RUC considered the source of the existing values for these services, the nature of the services described by the new codes, and how the new codes would be used relative to the deleted codes. The RUC noted that, because vascular surgeons were not included in the Harvard RBRVS study, the RUC-recommended relative values for these services are the first to be based on a survey of practicing vascular surgeons.

In considering the recommendations for new codes 35390 and 35700, the specialty indicated that reoperations would previously have been coded using modifier -22. The RUC compared these services to reoperations for coronary arteries bypass graft (code 33530, 6.01 RVW) and found the recommendation to be appropriate. The new codes 35694 and 35695 are considered equivalent in work. They both involve more work than synthetic grafts but less work than vein grafts. New code 35876 would previously have been reported using the revised code 35875. The RUC therefore recommends that the

value of 35875 be reduced to 9.84 from its current value of 10.86. The deleted codes 35900 and 35910 have been replaced with codes 35901 - 35907. The specialty noted that excision of an infected extremity graft (35903) is most common and excision of an infected graft in the thorax (35905) is rare. When revascularization is necessary, the 50% reduction would be applied to the reported revascularization code. For example, if the most common excision of an infected extremity graft required revascularization, code 35556 (Bypass graft, with vein; femoral-popliteal) would be reported and the total work value of 20.22 ($12.00 + (16.43 \times .50)$) would be less than the value of deleted code 35910 (28.89). The specialty also indicated that revascularization after excision of an infected thorax graft would be rare. The RUC also discussed the frequency with which the service described by the new code 37607 would involve banding versus ligation. The specialty reported that banding would be much more common and more difficult, because the surgeon must band tight enough to stop the excess flow but maintain the functioning of the arteriovenous fistula.

12. Cardiovascular Stress Testing [Tab 15]

Tracking Number: AQ1-AQ2

Presentation: Joe R. Wise, MD

American College of Cardiology

The RUC recommendations are based on the survey median of .46 for the new code 93016 which describes the physician supervision only. Recognizing that the physician supervision of the service requires more effort than the separate interpretation and report component, the RUC is recommending a reduction in the value for the existing code 93018 (interpretation and report only) from .46 to .30. The combination of these two codes should equal the existing value assigned to the complete code 93015 (.76).

13. Patient Demand Event Recording [Tab 16]

Tracking Numbers: AR1

Presentation: Joe R. Wise, MD

American College of Cardiology

The RUC recommendation of .54 is based upon the comparison with code 93224. The physician work involved in 93224, review and interpretation of data from a 24-hour ambulatory monitor, is nearly identical to 93628, which includes reviewing an average 4-5 ECG strips transmitted by a patient per 30-day period of time.

14. Pacemaker/Electrophysiology [Tab 17]

Tracking Numbers: AS1-AS42




Presentation: Joe R. Wise, MD

American College of Cardiology

Due to concerns about the low response rate (9 respondents) to the survey, the committee adopted a motion to table AS1 through AS32 (pacemaker services). Doctor Rodkey advised the cardiologists that if they returned with recommendations at the November meeting, the RUC would be able to forward its recommendations to HCFA during the public comment period for the 1994 Medicare RBRVS if they were different from the interim values published by HCFA.

In evaluating the electrophysiology services, the RUC considered the overall procedures and how much work is done by the surgeon versus the work done by the cardiologist. For several of the revised codes in this section, the RUC recommends that the current value be maintained. Recommendations for the new

codes generally reflect the survey results, but in evaluating the specialty recommendations the RUC also considered the following issues:

-  Code 93624 has been revised to include induction of arrhythmia. The key reference service is 93618 which requires slightly less work than 93624, as it does not require placement of a catheter. It was noted that an electrophysiologic follow-up study without induction is rarely done. The RUC concluded that the addition of "including induction of arrhythmia" and the comparison to 93618 justified the increase in value to 4.92.
-  New code 93641 is comparable to 93620, however, it does not require the physician to put in percutaneous catheters. The RUC evaluated the intra-service time of the service (120 minutes), which includes the programming of the device and measurements. 93641 also includes an additional level of complexity with multiple testing of the device to see if one can detect and delineate different arrhythmias. As many as 10-15 inductions may be used, which creates a high level of intensity and makes the procedure especially challenging.
-  The RUC considered the group of codes described by revised code 93650 and the two new codes 93651 and 93652. Assuming the frequency of the three codes will now be 93650-25%, 93651-50%, and 93652-25%, the RUC computed work neutral recommendations for 93650 and the two new codes. 93651 and 93652 are very labor intensive and more complex procedures which represent new technology. Code 93651, which can be performed in a catheterization lab, has reduced the need for surgical ablation which has a much higher relative value.

15. Congenital Heart Procedures [Tab 18]
Tracking Numbers: AT17-AT19, AT32-AT112
Presentation: John Mayer, MD
The Society of Thoracic Surgeons
American Association of Thoracic Surgery

The RUC's evaluation of the extensive revisions in CPT codes for congenital heart procedures focused principally on the survey data obtained from the specialty. A survey of 40 surgeons yielded 34 responses (85%), with ratings clustered extremely closely around the survey medians forming the basis for all of these recommendations. Surveyed physicians were selected based on their familiarity with both pediatric and adult cardiac surgery, in part to assure their familiarity with the reference procedures as well as the procedures being rated, since many of the existing pediatric congenital heart procedures have values in the current RVS of 0.00.

16a. Video-Assisted Thoracic Surgery [Tab 19]
Tracking Numbers: YY1-YY22
Presentation: Peter Pairolero, MD
The Society of Thoracic Surgeons
American Association of Thoracic Surgery

In considering the recommendations for the thoracoscopy codes (YY1 through YY22), the RUC discussed the greater complexity involved in video-assisted thoracic surgery of the mediastinum compared with the pleural cavity because of the need for the surgeon to traverse the pleural cavity in order to get to the mediastinum. The RUC also discussed the appropriateness of the "000" global period estimate for the diagnostic thoracoscopy procedures (codes 32601-32606) in light of the reported hospital stays of three days, the number of post-hospital visits associated with these procedures, the specialty's

statement that the recommendations reflected the total work of the service including all postoperative care, and the key reference services, which are open procedures with 90-day global periods. The RUC is recommending that a global period of "010" (10 days) be assigned to all six of these procedures. The RUC did note, however, that payment policies should still permit physicians to report codes for the subsequent definitive therapy that may be initiated during the 010 day global period for the diagnostic procedure.

16b. General Thoracic Procedures [Tab 19]




Tracking Numbers: AT1-AT16

Presentation: Peter Pairolero, MD

Society of Thoracic Surgeons

American Association of Thoracic Surgery

The RUC analyzed the manner in which the CPT Editorial Panel had split the existing pneumonectomy codes into larger families of codes and focused on the relationships between the existing codes with currently assigned relative values and the new codes:

-  The work involved in 32442 is considered to be more intensive than 32440 because of the need to make sure the endotracheal tube is properly placed.
-  The value of code 32445 represents a simple average of the values currently assigned to 32445 and 32450, which has been deleted. Although the specialty indicated that 74 of the 101 cases submitted under the Medicare program were coded as 32445, the RUC did not believe it would be appropriate to use a weighted average based only on Medicare claims data.
-  A reduction is recommended in the current value assigned to 32480 from 17.85 to 17.25. It was noted that 32482 would previously have been coded using a modifier for bilateral procedures and that 32484 would previously have been coded using 32480 with modifier -22. The ratio of pneumonectomy procedures coded as 32480 (as revised) relative to the new code 32484 is estimated to be 100:1.

Comparisons were made between the work involved in lung transplant procedures with that of kidney transplants, as well as the work of harvesting lungs relative to hearts. Harvesting the lungs alone is more work than either the heart alone or the total heart/lung block. The RUC's discussion of the lung transplant codes noted that the removal of a lung from a donor is more difficult than removal from a living patient because of the need to preserve the lung and its susceptibility to the external environment. The RUC also discussed the increased intensity associated with the double lung transplant compared to the single lung transplant due to the inability to rely on the healthy lung if complications arise from the transplant.

17. Thoracic Surgery: Adult Cardiac Procedures [Tab 20]

Tracking Numbers: AT20-AT31

Presentation: Sidney Levitsky, MD

Society of Thoracic Surgeons

American Association of Thoracic Surgery

As with the pneumonectomy procedures, the RUC's evaluation of the adult cardiac procedures focused on the ratios of the new codes to the current codes for adult cardiac procedures with assigned relative values.

The RUC recommended that the current value of 24.13 for code 33460 be reduced to 23.13 to reflect the deletion of code 33452 for valvotomy. Likewise, the RUC recommended that the value of code 33860 be

reduced from the current value of 35.09 to 34.74 and that new code 33861 be assigned a value of 35.00, which is somewhat less than the current value of 33860, to allow for the greater work involved in the new code 33863 relative to the other two procedures. New code 33973 is an entirely new operation that has evolved over the past 5 years. It is likely to be done when the chest is already open, in which case modifier -51 would be used. The new code 33974 would require a return trip to the operating room, however. The RUC's discussion noted the increased difficulty of procedures involving the ascending aorta compared with those involving the femoral artery. 33973 would currently be coded using an unlisted procedure code or modifier -22. New codes 33975-33978 describe use of new technologies recently approved by the FDA. They involve a separate operation that frequently takes place during the global period following a cardiac operation.

[CHANGE TRACKING NUMBERS BELOW TO ACTUAL CODE NUMBERS TO BE CONSISTENT WITH REMAINDER OF DISCUSSION]

AT4, AT11, AT14, 38860, AT22, AT24, AT25, AT26, AT27, AT30, AT31, and 33460 were sent to Facilitation Committee. The member of the committee were Doctor Maves (Chair), Doctor Miller, Doctor Tudor, Doctor Gage, and Doctor Gee. The committee examined the values recommended on the ballots and adjusted the recommendations to reflect these suggestions. For the two current codes that had not been assigned a tracking number, the committee also considered the ratios in the new family of procedures and adjusted the current values accordingly.

18. Positron Emission Tomography (PET) [Tab 21]

Tracking Numbers: AM1-AM2

Presentation: Robert Carretta, MD; W. Max Cloud, MD

American College of Nuclear Physicians

Society of Nuclear Medicine

American College of Radiology

The RUC recommendation is based upon the survey median of approximately 40 nuclear physicians and radiologists and the comparison to code 70552 (MRI, brain, with contrast materials). The PET codes and 70552 require identical amounts of time and interaction between physician and technologist. An MRI procedure with contrast was used as a key reference service as an injection is also required for PET. Although the physician work in PET will be the same as MRI, the practice costs are higher as PET scans are more costly. PET has not been coded previously and is considered new technology, although the technology has been in use for several years.

19. SPECT Imaging [Tab 22]

Tracking Numbers: AN1

Presentation: Robert Carretta, MD; W. Max Cloud, MD

American College of Nuclear Physicians

Society of Nuclear Medicine

American College of Radiology

The RUC recommendation is based on survey responses from more than 60 nuclear physicians and radiologists, more than twice the number required by the RUC. The recommended value reflects the work involved in the key reference service 78803 (tumor localization) as the abscess localization by SPECT is clinically equivalent to tumor localization by SPECT. Responsibilities for the new code 78807 include oversight of the white blood cell tagging procedure to insure proper labelling technique and

increased physician liability related to reinjection of blood into the patient. White blood cell tagging is specific to this procedure and not part of code 78803, which was the designated reference service.

20. Three-Dimensional Reconstruction of Tumor [Tab 23]

Tracking Number: AK1

Presentation: W. Max Cloud, MD; Paul E. Wallner, MD
American College of Radiology

The committee referred the recommendation back to the specialty society.

21. Radiation Treatment [Tab 24]

Tracking Numbers: AL1, AL2

Presentation: W. Max Cloud, MD; Paul E. Wallner, MD
American College of Radiology
American Society for Therapeutic Radiology and Oncology

The committee referred the recommendations back to the specialty society.

22. Dual Energy X-ray Absorptiometry (DEXA) [Tab 25]

Tracking Number: AH1

Presentation: W. Max Cloud, MD
American College of Radiology

The recommendation was withdrawn by the specialty society due to the low survey response rate.

23. Gastrointestinal Endoscopic Ultrasound [Tab 26]

Tracking Numbers: T1-T2

Presentation: Arnold M. Rosen, MD
American Society for Gastrointestinal Endoscopy
American College of Gastroenterology

The ASGE/ACG re-submitted a recommendation of 6.11 RVW for T1, Gastrointestinal Endoscopic Ultrasound (new CPT code 46XXX)[I'M SURE THE CPT CODE NUMBER IS NOT STILL 46XXX], which had originally been presented at the April 30-May 1 meeting. The RUC had asked for a second survey to be conducted of the work involved in new code 43259 because respondents to the first survey did not appear to have a clear understanding of what they were rating. The code applies to upper endoscopy only and the second survey yielded a fairly tight distribution of responses around the RUC-recommended value of 6.11, which is equivalent in value to endoscopic retrograde cholangiopancreatography (ERCP). The recommended value for the endoscopic ultrasound procedure also includes the work of the upper GI endoscopy that would be performed on the same day and has a value of 2.45. The RUC's discussion of the recommendation included an extensive discussion of the clinical nature and complexity of performing endoscopic ultrasound.

24. Gastrointestinal Endoscopy [Tab 27]

Tracking Numbers: AD1-AD28

Presentation: Arnold M. Rosen, MD
American Society for Gastrointestinal Endoscopy
American College of Surgeons

The coding changes made in the gastrointestinal endoscopy section of CPT are quite extensive. The RUC considered many of the revisions to be editorial in nature, however, and is not recommending any change in relative value. For a number of the codes in this section, the RUC recommendations are based on an approach termed "valuing the increment." The endoscopic specialty societies have already worked with HCFA prior to HCFA's refinement process to identify consistent physician work relationships between basic endoscopic procedures and other procedures included in these services, such as biopsies and removal of polyps and lesions. These increments were considered in developing the RUC's recommendations, along with the identified key reference services and survey data from about 40 physicians specializing in endoscopy and endoscopic surgery.

25. Colon and Rectal Surgery [Tab 28]

Tracking Numbers: ZZ1-ZZ7

Presentation: Steven Stryker, MD

American Society of Colon and Rectal Surgeons

American College of Surgeons

The RUC's evaluation of these codes included a thorough discussion of the relationships between the deleted codes 44600 and 44610 and the new colon and rectal surgery codes 44602-44604. New code 44615 is not included in the cross references in CPT and was valued based on the survey results. The RUC concluded that new code 44602 should have the same value as the deleted code 44600 since 44600 would have been used to report this service previously. CPT Code 44600 has been deleted and replaced with separate descriptors for small bowel repair (single or multiple) and large bowel repair (single or multiple with or without colostomy). 44603 and 44604 were felt to be identical in work because, although 44603 requires more intraservice time to suture more perforations, there are fewer postoperative complications, so the same value as the deleted code 44610 is recommended for both.

The RUC also discussed the recommendation that the intestinal suture be valued higher when there is no colostomy than when it is done with colostomy. The RUC concluded that the direct repair of the intestine without use of colostomy is a more complex and intense procedure for the operating surgeon.

New code 90911 was proposed because anorectal manometry and EMG are frequently bundled together. The value of the new code was obtained by adding the value for EMG to the existing value for anorectal manometry (code 91122, 1.81 RVW).

26. Lymphadenectomy [Tab 19 and Tab 29]

Tracking numbers: S1, S2

Presentation: Paul Collicott, MD; Peter Pairolero, MD

American College of Surgeons

Society of Thoracic Surgeons

American Association of Thoracic Surgery

The RUC discussed the add-on nature of these procedures and accepted the specialty rationales that were presented. Comparisons were also made with procedures such as radical nephrectomy and radical mastectomy, which include removal of the lymph nodes, but the RUC concluded that the procedures for which the lymphadenectomy would be a separate add-on were substantially different from these radical procedures.

27. Hernia Repair (Other than Pediatric) [Tab 30]

Tracking numbers: U18

Presentation: Paul Collicott, MD; Peter Pairolero, MD
American College of Surgeons

The new code 49568, an add-on code for implantation of mesh or other prosthesis for incisional hernia repair, was referred back to the general surgeons for a resurvey after the April 30-May 2 meeting because the initial survey did not appear to make clear the add-on nature of the service. In evaluating this recommendation, it was clear that the addition of the mesh would add considerable work to the service because the hernia would be a very large one, there would be scars from previous surgery, and because of the interspersing of omentum or tissue between the bowel and the mesh. In addition, there is increased risk of postoperative infection due to the prosthetic implant.

28. Breast Lesion Excision [Tab 31]
Tracking numbers: DD1-DD2
Presentation: Paul Collicott, MD
American College of Surgeons

The two new codes, DD1 and DD2, were designed to bring the breast lesion excision section of CPT up to date. They describe the extra work that is involved when excising lesions that have been identified by the radiological marker, as compared with a palpable lesion. The procedure requires the surgeon to spend more time in the operating room because of the need for mammography and for more dissection than is required with a palpable mass. The lesion is first localized pre-operatively, the area is biopsied, and the biopsy is sent to the radiology laboratory. The patient may require further biopsy before close or before a "lumpectomy" with reconstruction.

29. Gastrectomy [Tab A]
Tracking numbers: AC1-AC7
Presentation: Paul Collicott, MD
American College of Surgeons

In evaluating the new and revised codes for partial gastrectomy, the RUC separately considered the relationships between the codes and the rationale presented for changing the work values for these procedures from their current level. The increments of work for Roux-en-Y reconstruction and formation of intestinal pouch are the same as those recommended by the RUC for these procedures when they are done for total gastrectomy. The RUC discussed a rationale for increasing the work values of the total gastrectomy codes at its May meeting, including changes in the nature, scope, and difficulty of gastrectomy over the past 20 years due to advances in endoscopic surgery and pharmacologic management of gastric disorders. At its June meeting, the RUC reaffirmed its acceptance of this rationale.

30. Pancreatic Surgery [Tab B]
Tracking numbers: AF1-AF11
Presentation: Paul Collicott, MD
American College of Surgeons

The RUC determined that the general surgeons had presented compelling evidence for changing the global period for the codes for treatment of pancreatitis from 90 days to zero days ("090" to "000") because the operative treatment of pancreatitis, while extremely difficult, is a relatively small part of the overall management of the patient with acute necrotizing pancreatitis.

The RUC also found the rationale for increasing the value of the Whipple-type procedure (48150) to be compelling. The recommended value of 43.00 was obtained by calculating 60% of the cumulative intraoperative work of all of the individual procedures included in the Whipple-type procedure. Telephone calls received from many of the physicians surveyed about the work of this procedure suggested the survey data on relative work were not reliable so the building block approach was used as an alternative. The RUC noted that a change should be made in the RUC's survey instrument related to the instruction that raters not change the value of the reference procedures in order to prevent a recurrence of this problem.

The RUC's discussion of this procedure also noted that it is associated with one of longest accepted lengths of hospital stay, which the survey indicates is an average of 21 days (the reliability of these data was not affected by the problem with the work estimates). The current value was not based on the Harvard study and was not addressed in HCFA's refinement process.

The RUC also considered the consistency of the relationships between the work values in this section, and maintained the same increment of work between the new codes 48153 and 48154 as that identified between code 48150 and new code new code 48152 in the survey process. New codes 48530 and 48532 are for new procedures that were not previously coded.

In the time between the CPT meeting and the RUC meeting, it was not possible to develop relative values for the transplant procedures in this section. They will be considered at a future RUC meeting.

31. Laparoscopic Assisted Surgical Procedures [Tab C]
Tracking numbers: AG1-AG6
Presentation: Paul Collicott, MD
American College of Surgeons

The RUC adopted recommendations in June for two of the six new codes added for laparoscopic assisted surgical procedures. The RUC noted that, in the absence of the two new codes for laparoscopic hernia repair, physicians would be likely to submit claims for these services using the codes for open repair with modifier -22 in order to obtain a higher payment than they would receive for the open procedure. Survey data were not available to provide a sound basis for valuing these codes, but the RUC is recommending that the laparoscopic procedures be assigned the same values as the corresponding open procedures because the committee does not believe the work of the laparoscopic procedures should continue to be valued higher than that of the open procedures. The remaining four codes, AG3-AG6[INSERT ACTUAL CODE NUMBERS TO BE CONSISTENT], were referred back to the specialty society for reconsideration at the November meeting.

32. Cardiac Catheterization [Tab D]
Tracking numbers: AP1, AP2, AP9, AP10,
Presentation: Joe R. Wise, MD; Robert Vogelzang, MD
American College of Cardiology
Society of Cardiovascular and Interventional Radiology

The recommendations were withdrawn by the specialty societies due to a low survey response rate.

33. Cardiovascular MRI [Tab E]
Tracking numbers: AO1-AO4

Presentation: W. Max Cloud, MD; Joe R. Wise, MD
American College of Cardiology
American College of Radiology

The RUC recommendations are based upon cardiology and radiology survey medians which were adjusted by valuing the original survey medians as a ratio to the current value of the base code 75552. The RUC accepted the specialties' explanation of the changes in this technology and the state of the art, as well as the patient population. These are generally more complex patients than those who would have had cardiac MRI before, and often those for whom other technologies have failed.

Since the advent of cardiac/cardiovascular MRI in the mid-1980s, the level of technology and associated applications has increased exponentially. In the past two years especially a number of technologies have developed permitting increased capabilities for imaging of cardiovascular disease. These include capabilities for imaging along the axes of the heart and vessels, three-dimensional imaging/display, dynamic imaging, and near-real-time imaging. This translates into imaging of more complex patients, increased diagnostic yield, and increased involvement and expertise by the physician. These technological advances have also decreased the frequency of other procedures, such as myelography, and cardiac MRI patients would not generally go on to have cardiac catheterization or angiography. The RUC also noted that many surgeons will not operate without a cardiac MRI.

34. Non-invasive Vascular Diagnostic Studies [Tab F]
Tracking numbers: AU1-AU3
Presentation: Joe R. Wise, MD; Robert Vogelzang, MD
American College of Cardiology
American College of Radiology
Society of Cardiovascular and Interventional Radiology

The RUC recommendations for the three new codes for non-invasive vascular diagnostic studies are based on several considerations, including the survey data obtained from more than 50 interventional radiologists, radiologists, and cardiologists; the current values assigned to the deleted codes 93920 and 93921; and the source of these current values. Even though these deleted codes were considered in HCFA's refinement process, the assigned values are not based on a survey of physicians providing the services, and the RUC found the survey data and the specialties' arguments sufficiently compelling that it believes some increase is warranted. The RUC recommendations use the current value of .41 for deleted code 93921 as a base value for new code 93922. Values for new codes 93923 and 93924 are based on the relationships identified in the survey. All three recommended values (.41, .78, and .85) are substantially lower than the survey medians and recommendations presented to the RUC by the specialties (.60, 1.14, and 1.24).

35. Gastrointestinal Tube Placement [Tab G]
Tracking numbers: AE1-AE3
Presentation: W. Max Cloud, MD; Robert Vogelzang, MD
American College of Radiology
Society for Cardiovascular and Interventional Radiology

The RUC recommendations are based upon the survey responses obtained from radiologists and interventional radiologists. New code 44500 will be used to report the introduction of a long gastrointestinal tube only. No change in value is recommended for revised code 74340, which is an editorial change only. The new code 74251 involves a radiologic examination of the small bowel via

enteroclysis tube. The RUC accepted the specialties' rationale that this is a difficult procedure as the tube is difficult to move from the stomach to the small bowel. If the injection is performed too quickly, reflux back to the stomach may occur. The radiologist may also need to spend additional time counseling the patient as intubation is required for this procedure.

36. Peritoneogram [Tab H]
Tracking numbers: AI1
Presentation: Robert Vogelzang, MD; W. Max Cloud, MD
American College of Radiology
Society for Cardiovascular and Interventional Radiology

The RUC recommendation is based on the survey median presented by radiology and interventional radiology. The work involved is equivalent to the supervision and interpretation of other image guided needle procedures. Peritoneogram is an uncommon procedure that is most often used to verify an inguinal hernia in the presence of unusual symptomatology, for example, when the surgeon is convinced that there is a hernia but cannot find it. The RUC's review also noted the increased risk associated with injection of contrast medium into the peritoneal cavity compared with injection of air. The key reference service is therefore service described by code 74280 which involves air contrast of the colon with high density barium (1.01 RVW).

37. Stereotactic Breast Biopsy [Tab I]
Tracking numbers: AJ1
Presentation: W. Max Cloud, MD; Robert Vogelzang, MD
American College of Radiology
Society of Cardiovascular and Interventional Radiology

The RUC recommendation is based on the survey median presented by radiology and interventional radiology. The RUC compared this code 76095 to 76096 (preoperative placement of needle localization, breast, radiological supervision and interpretation) and determined 76096 to be much less work. 76095 involves the interpretation of multiple mammogram during the biopsy that will provide the surgeon with a road map to very small palpable lesions. This procedure represents new technology.

38. Chemical Peels [Tab J]
Tracking numbers: AX1-AX4
Presentation: June K. Robinson, MD
American Academy of Dermatology
American Society of Dermatologic Surgery
Society of Investigative Dermatology
American Society of Plastic and Reconstructive Surgeons
American Association of Plastic Surgery
American Society of Maxillofacial Surgeons

Committee members noted that the recommended values were higher than values for other procedures that involve more physician work, such as fistula repair, orchiopexy, hernia repair for a child, and appendectomy. The recommendations were referred back to the specialty society.

39. Intravesical Chemotherapy Administration [Tab K]
Tracking numbers: AY1-AY2
Presentation: June K. Robinson, MD

American Academy of Dermatology
American Society of Dermatologic Surgery
Society of Investigative Dermatology

In evaluating the work involved in new codes 96405 and 96406, the RUC rejected the survey results obtained from dermatologists because the evaluation and management services provided to the patients had not been separated from the work involved in administering the chemotherapy. At the dermatologists' request, the RUC recommended that these codes have the same value as the intralesional injections procedures described by codes 11900 and 11901 and that any separately identifiable evaluation and management services be separately reported. The RUC indicated that it would consider new survey data from the dermatologists at its November meeting and, if appropriate, provide a new recommendation to HCFA during the comment period on the 1994 RBRVS interim values.

40. Endoscopic Sinus Surgery [Tab L]
Tracking numbers: EE1-EE35
Presentation: Charles F. Koopman, MD
American Academy of Otolaryngology - Head and Neck Surgery

The coding revisions to endoscopic sinus surgery represent the recent advances in surgical technique. The RUC first reviewed this issue at its April meeting. After extensive discussion regarding the CPT descriptors for the diagnostic codes and the need for the society to restudy the RVW recommendations, the entire issue was withdrawn by the otolaryngologists until it could be reconsidered at the June RUC meeting.

The RUC recommendations for 31231, 31233, 31235, 31237, 31238, 31287, 31288, and 31240 are based on the survey of practicing otolaryngologists. Codes 31245-31251; 31261-31271; and 31280-31286 were reviewed as three related families. The value of the first code in each family (31245, 31261, and 31280) is derived from the survey. For the successive codes in each family, an "average increment" was calculated from survey medians and applied in a uniform fashion to each family. For example, the differences between the survey medians for 31245 and 31246, between 31261 and 31262, and between 31280 and 31281 were averaged and added to 31245, 31261, and 31280 to derive the recommended values for 31246, 31262, and 31282. In this fashion, the increments applied to successive codes within each family are uniform across the three families.

The RUC considered the values for each of the codes discussed above to be appropriate. The RUC did not, however, adopt recommendations for codes 31239 and 31290-31294 at the June meeting and referred these codes back to the specialty for further study.

41. Fistulization of Sclera for Glaucoma [Tab M]
Tracking numbers: AZ1-AZ2
Presentation: Stephen Kamenetsky, MD
American Academy of Ophthalmology

The RUC accepted the ophthalmology argument that the current value of code 66170, which was assigned through HCFA's refinement process, is still appropriate. The success rate for this procedure is 80-85%, so from 15-20% of patients may become eligible for the reoperation described by the new code 66172. 66172 represents a considerably more complex procedure because the eyes are more damaged and there is scar tissue from the previous surgery.

42. Hyperbaric Oxygen Therapy [Tab N]
Tracking number: BC1
Presentation: Kelly Hill, MD
American College of Emergency Physicians
American College of Hyperbaric Medicine

The committee raised questions about whether the procedure requires a sufficient amount of physician involvement to justify the recommended value. The recommendation was referred back to the specialty society for reconsideration.

43. Work Hardening [Tab O]
Tracking numbers: QQ1-QQ2
Presentation: Stephen Ribaudo, MD, American Academy of Physical Medicine and Rehabilitation; Stephen Levine, PT, American Physical Therapy Association; Debbie Holmes-Enix, OTR, American Occupational Therapy Association

The committee questioned how much time the provider spends in direct contact with the patient. There was a motion to table the recommendation until the November meeting. The motion passed.

44. Physical Medicine [Tab P]
Tracking numbers: RR1
Presentation: Stephen Ribaud, MD; Stephen Levine, PT
American Academy of Physical Medicine and Rehabilitation
American Physical Therapy Association

The specialty society withdrew the recommendation.

45. Polysomnography/Sleep Studies [Tab Q]
Tracking numbers: BD1-BD3
Presentation: Bruce Sigsbee, MD; Rahul Sangal, MD
American Academy of Neurology
American College of Chest Physicians
American Thoracic Society
American Psychiatric Association
American Sleep Disorders Association

The RUC considered the recommendations for the new polysomnography series to be a straight unbundling of the deleted parent code, 95828. The three new codes reflect a change in the diagnostic procedures for sleep disorders. The series essentially replaces the high-end of the old services. The recommendations reflect the consensus of neurologists, pulmonologists, psychiatrists, and physicians specializing in sleep disorders. Frequencies and weighted averages were used in the calculation of the RVU for each code:

95807	1.70 RVW with an expected frequency of 37%
95808	2.71 RVW with an expected frequency of 14%
95810	3.61 RVW with an expected frequency of 49%

The weighted mean of these recommendations is 2.78 which is slightly less than the current value of 2.79 for the deleted polysomnography code 95828.

46. Neuropsychological Testing [Tab R]
Tracking numbers: PP1-PP4
Presentation: Nancy Willcockson, PhD; Bruce Sigsbee, MD
American Academy of Neurology
American Psychological Association

The RUC recommendations are based on a downward adjustment of survey results from more than 50 neurologists and clinical psychologists to better reflect the relationship between the revised codes and the key reference services 90801, 90844, 99204, and 99244. The neurobehavioral status exam (95882) and neuropsychological testing battery (95883) are considered approximately 10% more work than assessment of aphasia (95880) or development testing (95881). It was also noted that the time required for the interpretation and report might be subsequent to the hour of development testing.





47. Psychological Testing [Tab S]
Tracking numbers: SS1
Presentation: Nancy K. Willcockson, PhD
American Psychiatric Association
American Psychological Association

The RUC recommendations are based on a downward adjustment of survey results from more than 50 clinical psychologists and psychiatrists to better reflect the relationship between the revised codes and the key reference services 90801, 90844, 95880 and 95881. The RUC critically evaluated the relationship between 90830 and 90844 (individual medical psychotherapy) and determined that, in addition to one hour of psychological testing, 90830 would also include pre-service time discussing the tests with the patient and/or family and up to 20 minutes of interpretation and report.

Other Issues

Research Issues

During the course of the RUC's consideration of this large number of recommendations, several methodological and procedural issues were raised repeatedly as matters of concern. In addition to the issues referred based on the Research Subcommittee report at the April 30-May 1 meeting, these issues have been referred to the Research Subcommittee to consider at its meeting on October 18:

-  "The Kwass Factor," which refers to the revaluation by the RUC of the relative values assigned to new and revised codes within a family of CPT codes that is revised and for which there are existing published relative values.
-  Development of a process defining how the RUC Health Care Professionals Advisory Committee will relate to the RUC and what methodologies might be used to develop relative values for services provided by MDs and non-MDs.
-  Improvement in procedures for addressing the global periods assigned to services, including assigning relative values to "add-on" codes with a ZZZ global period and the more general issues involved in assessing pre- and post-service work and comparing the work of services with different global periods.
-  Development of a methodology for RUC involvement in wider review and refinement of physician work relative values beyond those codes that are revised or added by CPT.

Cross-Specialty Reference Services

After discussing the possibility of holding a separate meeting devoted to the cross-specialty reference services list, the RUC adopted a motion to have the chair appoint a subcommittee to consider the next steps in development of the list and report back to the full committee. The subcommittee was directed to review the codes and values on the lists generated by the RUC's review to date and to make recommendations for its use. The subcommittee will meet Thursday, November 18, in Orlando.

Update on CPT Editorial Panel

In a report on CPT, Doctor Gordy said that the Editorial Panel discussed some of the RUC's recommendations before the book was sent to the printer. No more changes can be made for 1994. The specialty societies were encouraged to submit their requests for coding changes early in the annual cycle, or, if possible, to submit a three-year plan for coding changes so that the CPT could assist them in preparing their proposals. Doctor Rodkey added that the specialty societies needed to prepare their recommendations early in the cycle so that the RUC could avoid another logjam of coding changes at the end of the year such as it was experiencing this year.

HCFA Update

Doctor Shekar emphasized HCFA's view that the RUC is a very important and valuable process because it is able to make recommendations on complicated intraspecialty issues. The agency would prefer to work actively with the RUC than attempt to micromanage the medical profession. Doctor Stone concurred that the RUC's efficiency has increased and that the volume of codes that it reviews is impressive.

Meeting of CPT/RUC Subcommittee on Pediatrics

Doctor Hanley reported on Thursday's meeting of the CPT/RUC Subcommittee on Pediatrics. The purpose of the meeting was to discuss completion of the RBRVS for children's health services. The Board of the American Academy of Pediatrics has endorsed the concept of using the RUC process to develop values for pediatric and other codes, beginning with those that have zero values (e.g., newborn and preventive services). This process began at this weekend's RUC meeting when the RUC adopted the joint recommendation of the Academy and the Society of Critical Care Medicine for the Neonatal Intensive Care codes. The recommendations for the preventive medicine codes will be discussed at the RUC's November meeting.