

**AMA/Specialty RVS Update Committee  
May 1-May 3, 1998**

**The JW Marriott Hotel  
Washington, DC**

**I. Call to Order and Opening Remarks.**

Doctor Hoehn called the meeting to order at 8:20 a.m. The following RUC members were in attendance:

James Hoehn, MD	Steve Levine, PT*
David Berland, MD	J. Leonard Lichtenfeld, MD
Joel Bradley, Jr., MD*	James S. Maloney, MD*
Melvin Britton, MD	John Mayer, MD
Thomas P. Cooper, MD*	David McCaffree, MD
Peter Dempsey, MD*	Clay Molstad, MD
Robert Florin, MD	William Rich, MD
John O. Gage, MD	Peter Sawchuck, MD*
William Gee, MD	Chester Schmidt, MD
Tracy R. Gordy, MD	Paul Schnur, MD
Larry P. Griffin, MD*	Bruce Sigsbee, MD
Kay K. Hanley, MD	Sheldon B. Taubman, MD
Alexander Hannenberg, MD	William Thorwarth, Jr., MD*
W. Benson Harer, MD	Laura Tosi, MD*
James Hayes, MD	John Tudor, MD
Richard J. Haynes, MD	Charles Vanchiere, MD
Emily Hill, PA-C	Richard Whitten, MD*
David F. Hitzeman, DO	William L. Winters, MD
Charles Koopmann Jr. MD	

(\*Indicates alternate member)

The following individuals also attended and were introduced by Doctor Hoehn: Terry Kay, Health Care Financing Administration (HCFA); Robert Dee, US General Accounting Office; William Mangold, MD Carrier Medical Director of Arizona and New Mexico; May Cohen, MD, Edward Rumble, MD, Ronald Smucker, MD, RBRVS Commission of Ontario; Col Bailey, John Popplewell, David Reddy, Medicare Schedule Review Task Force of Australia and Patrick Gallagher, new AMA staff to the RUC.

**Approval of February 7-8, 1998 Minutes**

The minutes of the February 7-8, 1998 RUC meeting were approved after the following revisions were noted:

- The third sentence of paragraph 3, on page 11, to read: “*The Research Subcommittee agreed that the worksheet is a starting point when reviewing open/closed procedures.*”

- The second sentence of paragraph 4 on page 14, to read: “*Doctor Hoehn announced that it is clear that we have not made full use of our advisors and alternates that know the process.*”

The minutes were approved as amended.

### **III. Calendar of Meeting Dates**

The RUC was informed that the September 25-27, 1998 RUC meeting will be held at the Walt Disney World Hilton in Orlando, Florida. Doctor Hoehn also announced that there will be a meeting this summer in Chicago on June 12, 1998 to discuss the National Proposed Rule Making (NPRM) on Resource Based Practice Expense Relative Values.

### **IV. CPT Update**

Doctor Reginald Harris gave the RUC an update regarding the status of the Evaluation and Management Documentation Guidelines, CPT-5, Correct Coding Initiative (CCI), and discussed several CPT Editorial Panel issues of particular interest to the RUC. The AMA Federation held a Evaluation and Management Guidelines “fly-in” meeting Monday, April 28, 1998 in which over 300 physicians, state and specialty societies attended. Doctor Harris explained that the AMA Federation is committed to changing the guidelines to reflect the commitment of physicians to place patients first which would require the following: an additional grace period of at least 6 months; a pilot study of the new guidelines before widespread implementation; educating and training by personnel and Medical Carriers to use guidelines both correctly and fairly; and a clear statement from HCFA on the use of fraud and abuse statements. HCFA representatives have acknowledged that the vast majority of physicians are honest and provide a public service to Medicare beneficiaries and continue to argue that the government audits and sanctions are intended to seek “deliberate ignorance” or “reckless regard” of the truth or falsity of information to defraud the government.

The CPT-5 project is currently underway, and its goal is to make improvements in the structure and processes of the Physicians Current Procedural Terminology (CPT). Changes will be made to the editorial process to allow greater participation and contributions from national medical specialty societies and to facilitate the development of new and revised CPT codes. CPT-5 will also produce needed and practical enhancements to the structure of CPT to reflect the coding demands of the modern dynamic health care system. Recommendations will be presented to the Editorial Panel for consideration and implementation in early 2000.

Doctor Harris also discussed several issues that will be discussed at the upcoming May and August CPT Editorial Panel Meetings. The May meeting will finalize the add-code

revisions and clarify modifiers. In addition, the Panel will address several new cardiology codes and new pathology/laboratory procedures. The Panel also plans to embark on the development of CPT 2000. The August Panel meeting plans on revising the CPT Coding Change Request Form and the add-on code issue related to the additional work associated with procedures performed in altered surgical fields.

## **V. HCFA Update**

Terry Kay, Director of the Division of Practitioner and Ambulatory Care provided an update on HCFA's recent activities related to the Medicare Fee Schedule, annual regulatory changes and lastly, internal changes that are occurring at HCFA. Mr. Kay announced that the NPRM scheduled to be available for comment May 1, 1998, will provide a detailed description of the new methodology as discussed at the practice expense meeting April 30, 1998. Any comments during the 90 day period will be reviewed closely by HCFA. Mr. Kay also discussed some of the internal changes at HCFA including: the retirement of Bart McCann, MD; the additions of Michael Hash as Deputy Administrator and Doctor Berenson as the Director of The Center for Health Plans and Providers.

Mr. Kay also discussed HCFA's upcoming Rules on Ambulatory Surgical Center Payment; the Hospital Outpatient Prospective Payment Systems; and payment for Outpatient Rehabilitation Services. HCFA may need input from the RUC HCPAC on these issues. HCFA is particularly concerned in reviewing differences in payment for the same service performed in different settings.

Mr. Kay also explained that HCFA has been working on the year 2000 issue and this has been responsible for some of the delay in implementing the Balanced Budget Act of 1997. HCFA is asking all physicians to make certain that their systems are updated for the year 2000 issue.

## **VI. Washington Update**

Sharon McIlrath, from the AMA's Washington Office, reviewed a number of legislative and regulatory initiatives of interest to medicine. On the legislative side, Ms. McIlrath discussed the status of the Patient's Bill of Rights Act of 1998; the status of the Tobacco Bills; and the President's Budget. She also updated members on the American Hospital Associations' Health Care Claims Guidance Act, co-sponsored by more than 120 legislators. This act, which is fully supported by the AMA, would set up a number of hurdles for imposition of fines and penalties under the federal False Claims Act. In addition, an extension was granted on the comment period for Stark self referral regulations. It is likely that some legislative relief will take place since Congressman Stark has agreed that some clarifications are needed.

Ms. McIlrath's major focus was on physician payment issues including the Proposed Rule and the changes that are in store for Hospital Outpatient Departments. HCFA plans to use a system that would collapse 7000 CPT codes into 300 groups for payment

purposes. MedPAC has recommended and the rule may also have a cap on outpatient expenditures. This would have the potential to move more services into ambulatory surgery centers or physicians offices which could push physicians over Medicare spending targets and heighten the risk of future reductions in the conversion factor. Lastly, MedPAC and several legislators are considering rationalizing or standardizing payments across all sites while other legislators are considering a single payment rate for all sites based on the level required in the most efficient and appropriate site.

## **VII. RUC HCPAC Review Board Report**

Emily Hill, PA-C reported that the RUC HCPAC Review Board met on Thursday April 30, 1998 to discuss Physical Medicine and Rehabilitation relative value recommendations.

### Physical Medicine and Rehabilitation

A CPT code was established to describe a spectrum of manual therapy techniques, including mobilization and manipulation. The new code 97140 *Manual therapy techniques, (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes* will replace five codes currently in use [97122,97250,97260,97261,97265]. The HCPAC Review Board questioned the cross specialty relativity of the proposed RVU of .50 compared to the Chiropractic Manipulative Techniques and Osteopathic Manipulative Technique codes, although they understood the recommendation was related to the family of Physical Medicine and Rehabilitation CPT codes. It was noted that the primary reference service codes 97110 Therapeutic procedure, one or more areas, each 15minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility; 97350 *Myofascial release/soft tissue mobilization, one or more regions*; and 97265 *Joint mobilization, one or more areas (peripheral or spinal)* have work value of 0.45. This was also the 25<sup>th</sup> percentile of the survey, which had a sample size of 97 physical and occupational therapists. The HCPAC Review Board agreed that a work value of 0.45 was an appropriate recommendation for 97140 as it allowed appropriate rank order to be maintained in the 97000 series of codes.

## **VII. Relative Value Recommendations for New or Revised Codes**

### **Pelvic Exenteration (Tab 5)**

**Presentation: Paul Collicott, MD, & Charles Mabry, MD, American College of Surgeons and Anthony Senagore, MD, American Society of Colon and Rectal Surgeons**

A new CPT code, 4511X, was developed to describe *Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tubes(s), with or without removal of ovary(s), or any combination thereof*. Currently, two CPT codes exist to describe pelvic exenteration procedures: CPT code 51597 *Pelvic*

*exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon colostomy or any combination thereof* (work RVU=38.35), and CPT code 58240 *Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum of colon and colostomy or any combination thereof* (work RVU= 38.39). Code 51597 is specific to vesicle, prostatic or urethral malignancy, and CPT code 58240 is specific to gynecologic malignancy. The exenteration performed for primary colorectal malignancy is not represented in these two codes.

The new code, 4511X, allows for several combinations of exenterative proctectomy with *en bloc* removal of other pelvic organs for treating colorectal cancers (i.e., proctectomy with one or more of: cystectomy and resection of the distal ureters; hysterectomy or cervicectomy; removal of tube(s); and/or ovary (s)). The exenteration reported under 45126 may be either primary (to treat *de novo* disease) or secondary (to treat recurrent disease). Additionally, 4511X specifies the actual purpose of the procedure (treatment of colorectal malignancy) and the defining combinations of organ resections added *en bloc* to exenterative proctectomy.

The RUC agreed that codes 4511X, 58240, and 51597 are equivalent in work and recommend an RVU of 38.39. The value is slightly less than the survey median of 38.40. The median is the result of responses collected from 47 general surgeons and colon and rectal surgeons, and is comparable to the work RVU's for CPT codes 58240 (RVU=38.39) and 51597 (RVU=38.35).

#### **Arteriovenous Regional Chemotherapy Perfusion (Tab 6)**

**Presentation: Charles Mabry, MD, American College of Surgeons**

CPT Code 3682X *Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation and regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites* was created to describe a unique combination of a highly invasive procedure with chemotherapy supported by a membrane oxygenator/perfusion device.

The specialty society chose to withdraw this issue from the May 1998 RUC agenda. The specialty society plans to present this code at the September 1998 RUC meeting, after adequate survey data is developed. Until that time, the RUC agrees with the specialty society that CPT code 3682X be "carrier priced." This service is infrequently performed with fewer than 1000 cases reported per year in all patient groups.

#### **Sentinel Node Biopsy (Tab 7)**

**Presentation: Charles Mabry, MD, American College of Surgeons**

A series of new sentinel biopsy codes were developed but subsequently withdrawn from the specialty as there was concern that these codes for cervical lymph node procedures would create concern for the coding of all types of sentinel nodes as well as the global periods assigned were inaccurate. The specialty society plans on resurvey these codes and would like the RUC consider this issue at the September 1998 RUC meeting.

**Laparoscopic Adrenalectomy (Tab 8), Tracking Number: E1**  
**Presentation: Charles Mabry, MD, American College of Surgeons**

CPT Code 5633X *Laparoscopy, surgical; with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal* was created to accurately describe the application of laparoscopy to adrenalectomy, and also allow for outcomes analysis or tracking of the laparoscopic procedure.

The specialty society chose to withdraw this issue from the May 1998 RUC agenda. The specialty society plans to present this code along with 56345 *Laparoscopic surgical; splenectomy* and 56347 *Laparoscopic surgical; jejunostomy (eg, for decompression or feeding)* at the September 1998 RUC meeting, when adequate survey data is developed. Until that time, the RUC agrees with the specialty society that CPT code 5633X be “carrier priced”. This laparoscopic procedure is relatively new and not commonly performed at this time.

**Pulmonary Function Procedure (Tab 9)**  
**Presentation: Allan Plummer, MD, American College of Chest Physician, American Thoracic Society**

Code 94060 *Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)*(work RVU=0.31) was revised for CPT 1999. The deletion of language in the later part of the description was editorial and did not result in a modified work RVU. As such, the RVU for 94060 should remain at 0.31.

CPT code 94620 *Pulmonary stress testing; simple eg, prolonged exercise test for bronchospasm with pre- and post spirometry* (work RVU=0.88) was also revised during this year’s CPT process. After a comprehensive review, the RUC concluded that additional information was needed prior to establishing a valid work value for the modified procedure. The code will be resurveyed in upcoming months. The RUC will provide a recommendation after consideration at the September 1998 RUC meeting.

Newly developed code 9462X1 *Pulmonary stress testing; complex (including measurement of CO<sub>2</sub> production, O<sub>2</sub> uptake, and electrocardiographic recordings)* will also be resurveyed along with 94620. Again, it was the RUC’s opinion that further data should be collected prior to the development of a valid physician work value. As such, the code is withdrawn from reconsideration during this cycle and will be presented at the September 1998 RUC meeting.

CPT code 9462X2 *Patient initiated spirometric recording per 30 day period of time; recording (includes hook- up reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)* was developed this year. The RUC analyzed the procedure description and corresponding information and concluded that no physician work was included in this service.

For newly created CPT codes numbered 94014 and 94016, the RUC developed interim values of .52 for both procedures. These codes describe patient initiated spirometric recordings per a 30-day period of time and the subsequent physician review and interpretation of the recordings. In determining the physician work values for 9462X2 *Patient initiated spirometric recording per 30 day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation* and for code 94016 *Patient initiated spirometric recording per 30 day period of time; physician review and interpretation only*, CPT code 93272 *Patient demand single or multiple event recording with presymptom memory loop, per 30 day period of time; physician review and interpretation only* (work RVU=0.52) was closely reviewed and considered to be an appropriate reference service. Although the survey median was 0.54 for both newly created codes 94014 and 94016, the RUC supports an interim value recommendation of 0.52 for both procedures. The recommended interim value represents the comparison to code 93272.

#### **Bronchoscopic Procedures (Tab 10)**

**Presentation: (waiting for marla Brichta on this name) American College of Chest Physicians, ?? American Thoracic Society, Sid Levitsky, MD, Society of Thoracic Surgeons**

A facilitation committee, Doctors Gee (Chair), Berland, Hanley, Lichtenfeld, Mayer, Taubman, Weiner, Hannenberg and Don Williamson (OD) met to consider this issue.

The RUC evaluated the specialty society's request to split out the brushings and bronchial alveolar lavage from the base code into the following codes: 31622 *Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washings*, 31623 *Bronchoscopy; with brushing or protected brushings*, and 31624 *Bronchoscopy; with bronchial alveolar lavage*. The RUC carefully reviewed the specialty's recommended values and corresponding documentation and determined that the specialty society should resurvey and bring it back for the RUC's review at the September RUC meeting. The RUC had specific concerns regarding the low survey response rate and the inaccurate projections of frequency information presented on the specialty society's Summary of Recommendation forms.

CPT code 32001 *Total lung lavage (unilateral)* was established as the currently used bronchoscopy code 32999 *Unlisted procedure, lungs and pleura* and does not adequately or correctly describe this procedure. Some carriers pay for this procedure with 32999 with a -22 modifier while other carriers do not. There seems to be significant confusion

in correctly documenting this procedure. The work involved in 32001 is very similar to reference procedure 32095 *Thoracotomy, limited, for biopsy of lung or pleura* (work RVW=8.36) (90 minutes intra-service time compared to 75 minutes). The RUC recommends a work RVW of 6.00 which is the survey median.

### **Bronchoscopy for Brachytherapy (Tab 11)**

**Presentation:** (waiting for Marla Brichta to call me on this one)

**, American College of Chest Physicians, American Thoracic Surgeons, Sid Levitsky, MD, Society of Thoracic Surgeons**

A facilitation committee, Doctors Gee (Chair), Berland, Hanley, Mayer, Taubman, Weiner, Hannenberg, and Don Williamson (OD) met to consider this issue.

A new code, 31643, was established to describe the services for *Bronchoscopy; with placement of catheter(s) for intracavitary radioelement application*. The code was developed as a result of ongoing issues related to the reporting of bronchoscopies for the placement of clinical brachtherapy catheters. Currently, the CPT code series of 31622-31656 is used to describe diagnostic and therapeutic bronchoscopic procedures. Prior to the creation of 31643, no code existed to accurately describe the bronchoscopic placement of clinical brachytherapy catheters.

Under 31643, a general bronchoscopy is performed, and under the fluoroscopic guidance, precise placement of a catheter (catheter site determination in conjunction with radiation oncologist) is performed and secured so that coughing will not tend to displace it. After placement of the catheter, fairly intense follow-up is required to be certain that the catheter is still in place during the delivery of radiation.

In determining a work RVU, the RUC reviewed code work values for similar services, such as those listed under 31625 *Bronchoscopy; with biopsy* (work RVU=3.37). In comparing the intra-service time for 31625 versus that required for 31643, the RUC concluded that 31643 required more time. Also taken into consideration was the respondent's survey median: 3.60.

In view of these discrepancies, the RUC recommends a work RVU of 3.50 for code 31643. This value represents a midpoint between the work RVU for 31625 (3.37) and the survey median (3.60).

### **Ventricular Assist Device (Tab 12)**

**Presentation:** Sid Levitsky, MD, Society of Thoracic Surgeons

CPT codes 33975, *Implantation of ventricular assist device; single ventricular support and* 33976, *Implantation of ventricular assist device; biventricular support* have undergone significant changes in the amount of physician work required since they were last surveyed in 1993. The technology of VAD implantation has changed both the level of work intensity during intraservice implantation and increased the post operative time since patients are being managed for months and even years with the device in place.

The RUC recommends that the global period on 99375 and 99376 be changed from 90 days to 10 days, thus allowing physicians to report E/M services between the 11<sup>th</sup> and the 90<sup>th</sup> postoperative days separately. The amount of post procedure work has increased exponentially since these codes were last surveyed in 1993. In 1993, the RUC survey showed that CPT code 99232 was performed 29 times for inpatient E/M services without any outpatient post-op E/M services with a total of 25.81 RVUs for post op E/M services [99232 X 29 @ .89=25.81]. Information from a recent survey of four centers who frequently performed VAD indicates that on average, 2 visits are performed per day during the hospital stay and one outpatient E/M service is performed each week after discharge from the hospital. If the global period were retained at 90 days, the E/M component of this service would need to reflect nearly 45.00 work RVUs. The RUC recommends an interim solution of changing the global period to 010 days and has requested the specialty society to conduct a survey for the next RUC meeting.

The work RVUs of 21.60 (CPT 33975) and 29.10 (99376) will be considered interim until adequate survey data developed and the specialty society presents these codes at the September 1998 RUC meeting.

### **Neurostimulator Analysis and Programming (Tab 13)**

**Presentation: Dean K. Naritoku, MD, American Academy of Neurology, Samuel J. Hassenbusch, MD,PHD, American Association of Neurological Surgeons**

A series of CPT codes, 95970 through 95975, was developed for neurostimulator analysis and programming.

Code 95940 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex neurostimulator pulse generator, without reprogramming* will replace deleted code 63690 *Electronic analysis of implanted neurostimulator pulse generator system (may include rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); without reprogramming of pulse generator*. The work value should remain the same at .45.

Newly developed 95971 was developed to report *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple neurostimulator pulse generator, with intraoperative or subsequent programming*. This code was previously reported under CPT code 63691 *Electronic analysis of implanted neurostimulator pulse generator system (may include rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); with reprogramming of pulse generator* (work RVU=.65). CPT code 63691 is a programming and analysis code for

neurostimulation that dates back to 1990. Code 63691 was designed to refer to the programming of existing implanted generators clinically available at that time. The generators used during this time allowed for the programming of only two electrode contacts. Thus, there were only two possible combinations of electrode polarity; one of them positive and one of them negative. Consequently, the generators allowed for only very limited changes in pulse width and frequency.

Today the simplest generator or receiver system for neurostimulation allows for the programming of a minimum of four electrode contacts. This results in approximately 64 possible electrode combinations. In addition, the available range for pulse width and frequency has increased significantly since the early 1990's.

Based on this information, it was evident that code 63691 did not adequately describe the work being performed, and as such, new codes were recently established through the CPT process. (Code 63961 was subsequently deleted.) In developing the work RVU, the survey median was .78.. The survey median time for 95971 (20 minutes) is greater than that for 63691

(15 minutes). In general, the survey median of .78 is 20% greater than 63691, a difference that is clearly explained by the increased time and complexity of the generators that are available today. The RUC supports this data and recommends .78 as the work RVU for 95971.

*Code 95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain or spinal cord neurostimulator pulse generator/transmitter, with intraoperative subsequent programming, first hour and 95973 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain or spinal cord neurostimulator pulse generator/transmitter, with intraoperative subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure) fall within the same family of codes. However 95972 and 95973 are very different from both deleted code 63691 and the new code 95971.*

Newly created 95972 and 95973 are used for programming with a “complex” spinal/brain neurostimulation system. In essence, such a system consists of: two “four-contact” leads (thus, eight total electrical contacts); or a single “eight-contact” lead; or two “eight contact” leads (thus 16 total electrical contacts). The number of possible electrode combinations for polarity and use ranges from over 100,000 to about 60 million, depending upon which of these three systems are used. Furthermore, many of the FDA approved “complex” systems allow three to four different combinations to be used at the same time thus increasing the possible stimulation settings by a factor of three to 10 times.

It was the consensus that a stepwise progression of RVW's based on their relationship to each other and 63691 was important. The stepwise progression consisted of reviewing the value for deleted code 69631 (for limited 1-lead, 2 contact systems), then 95971 (for limited 1-lead, 4 contact systems), then 95973 (for thirty minutes of additional work with complex 2-lead, 4 contact or 1 –2 lead, 8-contact systems), and finally, 95972 (for the first 60 minutes of work with complex 2-lead, 4 contact or 1- or 2 lead, 8-contact systems).

Code 95972 refers to the initial 60 minutes of programming for a complex neurostimulation system. The relationship of 95972 and 95973, however, is not a straightforward time difference. As more programming ensues, the difficulty and complexity increases. It was agreed that the work RVU for 95972 should be less than twice the work RVU for 95973. The survey median for 95972 was 1.50 and is supported by the RUC. This work RVU recommendation is only 1.6 times the value for 95973 (even though the time is 2.0 times greater) and takes into account the increased time and complexity for each additional 30 minutes after the first hour. Again, the RUC supports a work RVU of 1.50 for code 95972.

Code 95973 refers to an additional 30 minutes of programming for a complex neurostimulation system. The intra-service intensity for 95972 and 95973 is 4.6, as compared to 2.9 for code 95971. Considering the time difference and considerably higher intensity, the survey median of .92 for code 95973 is recommended. The recommendation is conservative as an 18% increase over the recommendation of .78 for 95971.

Codes 95974 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour* and 95975 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)* are similar to codes 95971 through 95973, but differ greatly in their difficulty and complexity. Whereas 95971 through 95973 deal primarily with modulation of sensory function as an endpoint, the activities associated with 95974 and 95975 have multiple endpoints, including anticipated seizure outcome and a wide variety of clinically significant adverse events. The latter result from the many functions of vagus nerve, which has intimate interactions with brain, heart, gastrointestinal system and laryngeal musculature. Since antiepileptic efficacy and adverse effects are directly associated with increases in vagal stimulation, the clinician must repeatedly balance the effects against each other to optimize therapy.

Code 95974 broadly describes the vagus nerve stimulator programming and is used primarily for both: 1) Intra-operative programming; and 2) Outpatient programming, which by nature utilizes interactive sessions with the patient on a single clinical visit. The intra-operative programming covers pre-operative planning, intra-operative manipulation, and post-operative management. During interactive programming, the physician must repeatedly “ramp-up” the stimulation parameters to push the patient to the limits of tolerance. When tolerance to the induced pain occurs, usually over 1-2 hours, the current is increased further until no further increases may be performed. At each step, the physician must clinically monitor the patient for pain, respiratory compromise (due to laryngeal constriction), cardiac and gastrointestinal symptoms. In summary, code 95974 covers 60 minutes of intra-operative work, and subsequent to outpatient work, the later involving the programming and “ramping up” with the patient and device. The RUC recommends an RVU of 3.00 for code 95974.

Code 95975 is an extension of 95974 for an additional 30 minutes of complex programming with the neurostimulator as outlined above, the programming is complex because it involves titrating the therapy both against anticipated clinical response and acute adverse events. The RUC supports a work RVU of 1.7 for code 95975.

#### **Add-On Codes (Tab 14)**

**Presentation: Stephen Kamenetzky, MD, American Academy of Ophthalmology**

In 1999, CPT will identify all add-on codes with consistent language within the code (“list separately in addition to code for primary procedure”) and also will list all of these add-on codes in a separate appendix. The RUC reviewed the list and identified one family of codes to be reviewed, codes 67320, 67331-67334, 67340 for all other codes, the RUC does not recommend a change in the work values. The family of add-on codes in the Strabismus Surgery section of CPT was reevaluated as they are currently identified as stand alone codes with a global period of 90 days. Previously, the descriptors for CPT codes 67320, 67331, 67332, 67334 and 67340 included not only the intraservice work described by the code, but also a number of unstated, but implied, services that are associated with pre service and post service work. These codes will now be identified as add-on codes with a global period of ZZZ and the work RVUs should be reduced accordingly.

The RUC recommends the following work values: 4.33 (67320); 4.06(67331); 4.49 (67332); 3.98 (66334); 4.93 (67340). The specialty society used an arithmetic adjustment to the work values of these procedural codes. These proposed values were established by reducing the current work values by 50% using rules for multiple surgical procedures performed on the same day. Also, the Harvard data indicates that 59% of the codes were for intra-work, further justifying these proposed work values.

#### **Confocal Scanning Laser Polimetry (Tab 15)**

**Presentation: Stephen Kamenetzky, MD, American Academy of Ophthalmology**

A new CPT code, 92135, *Scanning computerized ophthalmic diagnostic imaging (e.g. scanning laser) with interpretation and report, unilateral* was developed to report the physician work involved in confocal scanning laser polimetry. Confocal scanning laser polimetry is an objective method for quantitatively determining the thickness of the retinal nerve fiber layer and analyzing change over time in the nerve fiber layer. Retinal nerve fiber layer assessment has long been known to be an early indicator of glaucomatous damage, with nerve fiber abnormalities appearing years before the visual field loss can be detected. Code 92135 represents an entirely new ophthalmological diagnostic modality not previously captured in CPT. Although similar to CPT 92225 (Ophthalmoscopy, extended) and code 92250 (fundus, photography), these codes fail to capture nerve fiber layer thickness measurement and unique nerve fiber polarimetry and its diagnostic value.

In determining the work RVU, respondents considered many existing CPT codes. Many physicians stated that 92135 (a unilateral code) was very similar to 92083 *Visual field examination, unilateral or bilateral with interpretation and report; extended examination*. Code 92083, a bilateral/unilateral code, describes comprehensive field vision services (work RVU=.50). Physicians agreed that the work involved in 92135 for one eye was greater than the work for 92083 when it is performed on one eye. It was also the consensus that, in general, 92135 was greater work than 92083. Code 92083 is almost always performed bilaterally making the unilateral work RVU=.25. In addition, 92135 requires more physician rather than technician input, and is more difficult to perform and interpret due to the volume of data.

Physicians also stated that the number of data points and physician work involved in 92135 were most closely approximated to that for 92235 *Fluorescein angiography (includes muliframe imaging) with interpretation and report* (work RVU=.81). However, the risk associated with 92135 is less than that of the fluorescein angiography reported under 92235. Finally, the physician work is less than for ophthalmic contact B scan currently valued at .66.

**Destruction of a Choroid Lesion (Tab 16):**

**Presentation: Stephen Kamenetzky, MD, & Ray Margherio, MD, American Academy of Ophthalmology**

CPT code 67210 *Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; photocoagulation* was closely analyzed during the Five Year Review. There was considerable concern with CPT code 67210 as there was a bimodal distribution of this procedure since the specific service being performed was for two distinct diagnoses. As a result, 67210 was referred to CPT and split into two codes, the revised 67210 and 67220 *Destruction of localized lesion of choroid (eg, choroidal neovascularization), one or more session, photocoagulation (laser)*.

In order to split the RVWs for 67210 into the two new codes each representing a distinct patient population and requiring different amounts of work while maintaining Medicare Budget neutrality, both survey data and Harvard methodology were used to calculate the recommended RVWs. The following estimates were made to examine the relationship between revised 67210 and 67220: the ratio between 67210 to 67220 previously reported as 67210 is 2.5 to 1.0; revised 67210 will require multiple sessions in approximately 20% of the patients treated; 67220 will require multiple sessions in approximately 50% of the patients treated; and the survey median RVW ratio of 7.0 to 9.0 accurately reflects the differences in work between revised 67210 and 67220 for ONE session

The Harvard methodology was then used to calculate intra-service RVWs by valuing pre-service work and HCFA methodology to value post-service work global E/M work. For the revised 67210, one additional session and one additional office visit equals 4.72 RVUs or .92 RVUs for a 20% retreatment rate; and for 67220, one additional session and two additional office visits equal 5.64 RVUs or 2.82 RVUs for a 50% retreatment rate. Adding these calculated RVUs for retreatments (0.92 and 2.82) to each code, results in a revised proportion of 7.94 to 11.82 RVWs based on the survey median RVWs of 7.0 and 9.0 for the two codes. These RVUs are then multiplied by the estimated frequency for each code, and sum is divided into the 1996 total billed RVUs, to arrive at an adjustment factor of 1.11. This adjustment factor is then multiplied by 7.94 and 11.82 to arrive at a RUC recommended RVW of 8.82 for the revised 67210 and a recommended RVW of 13.13 for 67220. These recommended values maintain budget neutrality.

### **Breast Reconstruction with Free Flap (Tab 17)**

**Presentation: John W. Derr, Jr., MD, & Steven Keller, MD, American Society of Plastic and Reconstructive Surgeons**

A facilitation committee, Doctors Hayes (Chair), Moorefield, Winters, Gage, Hitzeman, Zwolak, and Emily Hill (PA-C) met to consider this issue.

Newly revised CPT code 19364 bundles CPT 1998 code 19364 and 15756 into one code. This revision was implemented to correct nomenclature confusion and to eliminate the necessity for reporting a separate free flap code for breast reconstruction services. Revised code 19364 now describes *Breast reconstruction with free flap (Includes harvesting of the flap, microvascular transfer, closure of the donor site, and inset shaping the flap into a breast)*.

The overall work of revised CPT 19364 is similar to CPT 20970 *Free osteocutaneous flap microvascular anastomosis; iliac crest* (work RVU= 43.06). Preoperative, intraoperative and postoperative components will vary depending on the defect being repaired. For example, more work is required for preoperative padding/positioning and postoperative splinting/therapy for free osteocutaneous repair of an open tibia fracture. However, the intraoperative work of CPT 19364 to functionally repair the abdominal donor site and fashion the flap at the recipient breast/ axilla site is more than for a repair

of an open tibia fracture. When used for face reconstruction, the intraoperative work of a free osteocutaneous flap is very similar to breast reconstruction.

It was the consensus that CPT 19364 is more work than CPT code 19367 *Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site*; (work RVU=25.73); 19368 *Breast reconstruction; with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis* (work RVU=32.42); and 19369 *Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure donor of site* (work RVU=29.82). Free tissue transfer requires a microvascular procedure for an anastomosis of the pedicle vessels in the new recipient location. This requires extensive dissection at the harvest site and additional work at the recipient location. Additionally, the free tissue transfer requires more technical skill and effort and adds to the stress of the procedure.

Again, the services provided under revised 19364 are currently reported using both 19364 (unrevised work RVU=29.04) and 15756 (work RVU=35.23). As a result, the total RVU's reported in this manner equals 49.75 [35.23 +14.52 (0.5 \*29.04)].

The RUC recommends acceptance of 41.00 as the work RVU for revised code 19364. The recommendation represents the survey median and is based on a value for codes 19367, 19368, and 19369. The RUC also considered the following rationales in making a determination: 1) Current reporting of this procedure; 2) Changes in the CPT nomenclature to omit 19364 as an add-on code; and 3) Comparison to code 32852. With regard to 32852, the RUC also noted that the intra-service time (390 minutes) of CPT 19364 was comparable to the intra-service time for CPT code 32852 *Lung transplant, single; with cardiopulmonary bypass* (work RVU= 41.80).

### **Burn Management (Tab 18)**

**Presentation: John Deer, MD American Society of Plastic and Reconstructive Surgeons, & Robert W. Gillespie, MD, American Burn Association**

A facilitation committee Doctors Hannenberg (Chair), Florin Koopman, Lichtenfeld, Sigsbee, Berland, Plummer and Steve Levine, PT met to consider this issue.

During the Five-Year Review of the RBRVS, CPT codes 15000, 15350, and 15400 were identified as add-on services, which did not specify area size, and the RUC referred these codes to CPT for further definition and clarification. A series of new codes have been established which identify size and location of the defect (skin graft); type of graft as well as burn and wound preparation and management procedures. The new codes replace local burn treatment codes (CPT 16040-16042) and now represent services which combine a base code for the initial 100 sq. cm and add-on codes for each for each additional 100 sq. cm (which is applicable to adults and children over 10) and each additional one percent of the body (apply to children under 10 or infants).

CPT codes 15000 and 15001 describe burn and wound preparation. The intra service time for both CPT 15000 (30 minutes) and 15001 (20 minutes) is very similar to CPT 15100 *Split graft, trunk, arms, legs; 100 sq. cm or less, or one percent of body area of infants and children (except 15050)(30 minutes)*. However, the intra-service intensity of 15000 (3.53 out of a 5.0 scale) and 15001 (3.16) is much greater than 15100 (2.77) as the depth of removing burned skin is two to five times the depth taken with 15100. Also the associated blood loss of 180-200 ml per 100-sq. cm is not uncommon and frequently requires electrocautery, sutures, pressure dressings and use of cryoprecipitates to control bleeding. Therefore, the RUC recommends a work RVW of 4.00 for 15000 and 2.75 for 15001, both of which are the survey median.

The graft work for CPT codes 15350 *Application of allograft, skin; 100 sq. cm or less*/15351 *Application of allograft, skin; each additional 100 sq. cm (List separately in addition to code for primary procedure)* and 15400 *Application of xenograft, skin; 100 sq. cm or less* /15401 *Application of xenograft, skin; each additional 100 sq. cm (List separately in addition to code for primary procedure)* are very similar to the paired codes 15100/15100. However, the initial graft codes 15350 and 15400 include not only the intraoperative work for grafting the first 100 sq. cm of allograft or xenograft, but also include the post operative hospital and office visits within a 90 global period. After a graft is placed, the surgeon monitors the patient in the hospital (and sometimes ICU) daily to looking for signs of infection and to determine when a new graft can be placed. Typically 2-3 weeks pass before the graft rejects and a new graft is placed. Patients with very large burns, who require large grafts of 500-900 sq. cm, are more immunosuppressed and take longer for rejection to occur (3-4 weeks). The combination of primary and add-on codes with recommended RVUs is justified when compared to billing each independent visit, eg 14 to 28 visits at 99231 would equal 8.96 to 17.95 RVUs does not even take into consideration the two hours of intraoperative work to place the graft. Therefore, the RUC recommends a work RVW of 4.00 for both 15350 and 15400, which is the survey median, and a work RVW of 1.00 for both 15401 and 15351, which is less than the survey median.

**Excision of Tendon Sheath/Capsular Lesion (Knee) (Tab 19) Tracking Number: Z1  
Presentation: Laura Lowe Tosi, MD, American Academy of Orthopaedic Surgeons**

A new CPT code, 27347, was developed to describe the procedure for *Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee*. No code existed previously to report this particular procedure, which is estimated to be performed in less than 300 medical patients each year.

Code 27347 is most similar to CPT code 27345 *Excision of synovial cyst of popliteal space (Baker's Cyst)* (work RVU= 5.92). Code 27345 involves the excision of either a bursal cyst or a true ganglion of the posterior knee capsule, while 27347 involves the excision within the joint. The pre-service and post-service time for 27347 are both comparable to that reported under the code 27345. However, the intra-service time for 27345 is slightly greater in that the exposure is more difficult to identify along with the protection of the cutaneous nerves and the popliteal vessels.

The specialty noted that the survey median was too high, as 27347 is less work than 27345. The RUC, therefore, recommends the survey 25<sup>th</sup> percentile work RVU at 5.78.

**Bypass Grafts (Tab 20), Tracking Numbers: CC1-CC3**  
**Presentation: Robert Zwolak, MD, The Society for Vascular Surgery**

New CPT codes were added to reflect the extra work involved in harvesting and anastomosing vein segments for use as arterial bypass grafts from locations other than the actual bypass site. In developing the work value recommendation for all three add-on codes, the specialty society realized that a problem existed between the three codes because of their inter relationship and the CPT definition. CPT code 35500 is defined by anatomic site, whereas CPT codes 35682 and 35683 are defined in terms of numbers of segments. Therefore, the specialty society will request reconsideration by CPT for CPT code 35500.

The RUC also recommends that CPT code 35681 *Bypass graft; composite, prosthetic and vein (List separately in addition to code for primary procedure)* be assigned a work value of 3.93, which was the RUC recommended work RVU during the Five Year review. This recommended value was based on a survey of general and vascular surgeons. This procedure is listed separately in addition to the code for the primary procedure, which could be any graft procedures. This reduction will eliminate the possibility of a rank order anomaly within this family of add-on codes.

The RUC recommends that CPT code 35682 *Bypass graft; autogenous composite, two segments of veins from two locations (List separately in addition to code for primary procedure)* be assigned a work value of 7.20 based on a survey of 37 vascular surgeons. The recommendation of 7.20 is based on the 25<sup>th</sup> percentile of the survey results.

The RUC recommends that CPT code 35683 *Bypass graft; autogenous composite, three or more segments of vein from two or more locations (List separately in addition to code for primary procedure)* be assigned a work RVU of 8.50 which is also the 25<sup>th</sup> percentile of the survey respondents. CPT code 35683 was valued slightly higher than CPT code 35682. Code 35683 involves harvesting more separate pieces of vein in which each additional segments add at least one more microvascular anastomosis to the physician work.

**Thrombectomy of Grafts (Tab 21), Tracking Numbers: (DD1-DD5)**

**Presentation: Robert Zwolak, MD, The Society for Vascular Surgery**

A series of codes were developed for the reporting of thrombectomy of graft procedures. The codes were developed following a request by HCFA that the definition of CPT 35875 *Thrombectomy of arterial or venous graft*; be clarified. In the past, this code was utilized by physicians for both thrombectomy of lower extremity arterial bypass graft and for thrombectomy of hemodialysis graft. During the Five-Year Review of the RBRVS, HCFA referred code 35875 to CPT for redefinition as the physician work for these services differed significantly, with thrombectomy of the arterial graft representing more work than thrombectomy of a hemodialysis graft. HCFA also requested that 36832 be split into three separate codes: one specifically for thrombectomy of hemodialysis grafts; one for revision of hemodialysis grafts without thrombectomy; and one for the revision of hemodialysis grafts.

The best procedural comparison for 35875 *Thrombectomy of arterial or venous graft; (other than hemodialysis graft or fistula)*; is 34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery by leg incision* (work RVU=9.13). Code 35875 is usually performed through a leg incision, similar to 34201. Balloon catheters are used in both procedures in a similar manner. Code 35875 involves more work than 34201 because the leg has already been operated upon, and dissection is typically carried out through dense scar. Code 35875 typically represents more intensity than the typical procedure performed under 34201. Also, code 35875 carries one day longer length of stay than 34201. Based on the survey median, the relationship to the current code 35875 and the comparison code 34201, the RUC recommends a RVW of 10.13 for code 35875.

CPT code 35876 was revised to describe *Thrombectomy of arterial or venous graft; with revision of arterial or venous graft*. The most commonly referenced code for the revised code 35656 *Bypass graft; with other than vein; femoral-popliteal* (work RVU=19.53). Code 35876 is designed specifically to exclude hemodialysis grafts. Survey respondents stated that 35656 requires 25 minutes more intra-service time than 35876, but that 35876 was greater in intensity. The services had equal lengths of stay. The specialty society subtracted 25 minutes of surgery time at an average IWPUT of .08 per minutes, resulting in a calculation of 19.53 minus 25\*0.08=17.53. Based on the survey median, extrapolation by unblending the current code 35876, and extrapolation from 35656, an RVW of 17.00 (the survey median) is recommended for code 35876.

Code 36832 was revised to report *Revision, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous, dialysis graft (separate procedure)*. Again, codes 35875, 35876, and 36832 are redefined codes created to distinctly separate services performed on arteriovenous hemodialysis access grafts from services performed on arterial or venous bypass grafts. The best comparison codes are 36821 *Arteriovenous anastomosis, direct any site (eg, Cimino type) (separate procedure)* (work RVU=8.93) and 36830 *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft*. The physician work of these two services bracket the

work of 36832 . CPT code 36821 is the creation of one vascular anastomosis in a virgin surgical field. CPT 36830 includes placement of two vascular anastomosis plus creation of a subcutaneous tunnel for the graft. The newly revised code, 36832, involves digging out a previously placed graft through a scarred surgical field, then revising one or both anastomosis, or the conduit itself.

The distribution of survey values for 36832 was very tight with the 25<sup>th</sup> percentile of 10.00 rvu, median survey value of 10.50 rvu, and 75<sup>th</sup> percentile of 12 rvu. This procedure was previously coded by using 36832 or 35876. The value of 36832 has not been examined since the Harvard study. This code was not a code for which the original RVW was ascertained. Based on the survey results, respondents stated that an RVW of 6.45 was significantly inadequate. The survey median for this code was 10.50. The RUC recommends an acceptance of 10.50.

Code 86833 was developed to describe *Revision, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)*. Again, the reference codes used in development of the RVU were codes 36821 and 36830. Code 36833 involves digging out a previously placed graft through a scarred surgical field, performing a Fogarty balloon catheter thrombectomy, and then revising one or both anastomoses, or the conduit itself. Altogether, this is very similar to the total intra-service work of placing a totally new dialysis graft at a virgin site (eg, 36830). Both the pre and post service work elements of 36833 are very similar to those in 36821 and 36830. The survey median of 11.95 is recommended by the RUC.

Newly created code 36831 *Thrombectomy, arterioveous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)* was created to capture services for hemodialysis graft thrombectomy procedures. Previously, no code existed to accurately report these specific procedures. The most commonly cited reference service for 36831 for CPT 34201 (previously cited, work RVU=9.13). Survey respondents cited a three-day hospital length of stay for 34201 vs. no days for newly created code 36831. Intra-service time for 34201 (75 minutes) was longer than that for 36831 (60 minutes). Based on the data, it was noted that the RVW for 36831 should be less than the RVW for 34201, by a greater margin than exists between the median survey of 9.00 RVU and the RVW for 34201 which is 9.13. Based on the slight differences in time and intensity between 36831 and 34201, an RVW of 8.00 (the 25<sup>th</sup> percentile) is recommended for 36831.

## **Radical Vaginectomy with Removal of Paracolpos (Tab 22), Tracking Numbers: J1-J7**

**Presentation: Mike Berman, MD & Barbara Levy, MD, American College of Obstetricians and Gynecologists**

A series of new codes have been established to capture the complexity of radical colpectomy procedures as the existing colpectomy codes are often performed for benign

conditions. Typically, gynecologic oncologists perform these procedures because of their complexity. Previous surgery has destroyed the usual anatomic landmarks and the absence of the uterus and cervix make dissection of the bladder, ureters, rectum, and urethra more difficult than a similar procedure CPT Code 58210 *Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)*.

The work described by 57107 *Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)* is an abdominal procedure rather than a vaginal procedure that requires removal of all the supporting tissues in the upper vagina. This procedure carries a very high risk of bladder dysfunction or injury requiring extended catheter care. The work involved in 57107 is most similar to 58210 (work RVU=28.55) even though the survey data shows a slightly lower median intra-service time and lower intensity rankings. These differences result primarily from the fact that 58210 includes a bilateral pelvic lymphadenectomy, while 57107 does not. Therefore, the RUC recommends the survey median work value of 23.00.

CPT code 57109 *Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)* is also very similar to CPT 58210 in the amount of physician work involved. However, survey respondents estimated more intra-service time for 57109 (240 minutes compared to 200 minutes for 58210). Both 57109 and 58210 have almost identical amounts of post-operative care and levels of intensity. The RUC recommends a work RVU of 27.00 which is the 25<sup>th</sup> percentile of the survey results.

CPT code 57111 *Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)* and 57112 *Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)* are both similar to the radical hysterectomy (58210). However, survey data show a higher median intra-service time 240 minutes (57111) and 200 (58210) and a corresponding higher intra-service intensity ranking 5(57111) and 4(58210). These differences reflect the greater demands on the physicians technical skill entailed in performing 57111. Because 58210 includes a bilateral pelvic lymphadenectomy, the RUC recommends a survey median 27.00 work RVUs which seemed most appropriate. According to survey data, this is an extremely rare procedure performed less than fifty times a year.

CPT 57112, is similar to 58210, but requires in total more physician work. Survey respondents estimated more intra-service time 270 minutes (57112) and 200 minutes (58210), higher levels of mental effort (5 compared to 4) and higher pre- and intra service time (pre-4.50 compared to 4 and intra-5 compared to 4). The higher intra-service work for 57112 is more technically challenging because previous surgery has destroyed the usual anatomic landmarks and the absence of the uterus and cervix make dissection of the bladder, ureters, rectum, and urethra more difficult. Also, 57112 is a very rare procedure

that is performed less than fifty times a year. Therefore, the RUC recommends a work RVU of 29.00 for CPT code 57112, which is survey median.

**Radiological Examination of the Knee (Tab 23), Tracking Number: G1-G3  
Presentation: Bill Thorwarth, Jr. MD, American College of Radiology**

Current CPT codes, 73560 *Radiologic examination, knee; one or two views*, 73562 *Radiological examination, knee; three views* and 73564 *Radiologic examination, knee; complete; four or more views* were revised in 1998 to reflect minor editorial changes. In an effort to confirm that no changes had occurred in the physician work values for these knee X-ray procedures, the specialty society surveyed 30 radiologists. Based on comprehensive survey information, the RUC recommends that no changes be made to the previously determined work RVU's which are 0.17 (73560), 0.18 (73562), and 0.22 (73564).

**Radiological Examination Stress Views (Tab 24), Tracking Number: W1  
Presentation: Laura Lowe Tosi, MD, American Academy of Orthopaedic Surgeons and William Thorwarth Jr., MD, American College of Radiology.**

A new CPT code 76006 was established to report the physician's work in performing musculoskeletal stress x-ray views. These views require direct physician involvement with manipulation and assessing the films (including all necessary measurements) to determine if they are adequate. This procedure is considered new work that is not previously in the system. Specialists primarily perform this procedure in the x-ray suite and therefore should not be considered an add-on to reading the x-ray. The increased surveyed time for 76006 (10-12 minutes) compared to 73600 *Radiologic examination, ankle; anteroposterior and lateral views* (2.5 minutes) is explained by the physician discussion with the patient and physician manipulation of the injured extremity. In addition, the intensity and complexity of 76006 is also greater than 73600. In comparison to CPT codes 76885 and 76886 (median time 15), the time for 76006 (median time 10), represents one-half to two thirds of the intra-service time. The RUC recommends a work RVW for 76006 which is both the survey median from the radiology survey and the approximately the 25<sup>th</sup> percentile from the orthopaedic surgeons survey.

**Thyroid Carcinoma Metastases Uptake (Tab 25)  
Presentation: William Thorwarth, MD, American College of Radiology, & Kenneth McKusick, MD, Society of Nuclear Medicine American College of Nuclear Medicine.**

A new code, 78020, was developed as an add-on for a thyroid carcinoma metastases uptake procedure. As indicated, code 78020 *Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)* is intended for use in reporting of services with code 78018.

Thyroid cancer therapy with I-131 may result in pulmonary fibrosis in patients with lung metastases. Dosimetric estimates may be derived from the whole body I-131 imaging that

are routinely performed prior to treatment, by measurement of the lung uptake and calculation of the percentage of the administered dose that is resident within the lung. Code 780X1 represents the resources that are employed to derive that uptake measurement. Further calculation of uptake outside of the lung permits selective modification of doses I-131 given to patients with bone lymph node metastases, with greater therapeutic effect.

Prior to development of 78020, there was no reporting mechanism for “uptake” with CPT 78018 *Thyroid carcinoma metastases imaging; whole body* (work RVU=.95). CPT 78016 *Thyroid carcinoma metastases imaging; with additional studies (eg urinary recovery)* (work RVU=.82) does not reflect the resources used in 78018 plus calculation of the metastases uptake. Again, the code 78020 was not designed for reporting in conjunction with 78015 or 78016.

The physician involvement for the procedure is focused on the review of the calculations, including decay factors used for the dose measurement, and the accuracy of the regions of interest used for the areas of metastases and/or lung. Physician review of data may result in recalculation by the physician, which occurs 20% of the time. The report of the result is included in the main body of the imaging data report.

The RUC recommends an RVW of .67. The recommendation represents the weighted average of the societies’ median final RVW’s. The RVW is appropriate given the number of sites calculated, the frequent need for recalculations, and that the data are instrumental in planning therapy for the patient.

#### **Liver Imaging (SPECT) (Tab 26)**

**Presentation: William Thorwarth, MD, American College of Radiology, & Kenneth McKusick, MD, Society of Nuclear Medicine American College of Nuclear Medicine.**

A new CPT code 78206 *Liver imaging (SPECT); with vascular flow* was established to report a hepatic hemangioma study which requires two phases, the initial flow and images, and a later delayed set of images. This procedure is specifically performed to diagnose a hepatic hemangioma. Although there are several methods to diagnose a hepatic hemangioma, this particular procedure is unique from other liver imaging in that it requires multiple phases and as opposed to most tumors, a hepatic hemangioma peruses slowly which is seen as absent flow and uptake initially and increased uptake of intravascular tracer on later images.

In the absence of a specific code, this procedure was most commonly reported as CPT 78445 *Non-cardiac vascular flow imaging (ie, angiography, venography)* (work RVU=.49) which does not reflect the prolonged planar imaging and flow evaluation required. The work involved in 78206 is very similar to the combination of two CPT codes, 78205 *Liver imaging (SPECT)* (work RVU=.71) and CPT Code 78455 [.71+.49 X 50%= .96]. The RUC accepted the specialty society recommendation of .96 for CPT 78206.

**Cardiac Blood Pool Imaging (Tab 27) Tracking Number: KK1-KK2**  
**Presentation: James D. Maloney, MD, American College of Cardiology, William Thorwarth Jr., MD, American College of Radiology, Kenneth A. McKusick, MD, Society of Nuclear Medicine**

CPT code 78472 *Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing* (work RVU= .98) was recently revised through the CPT process. However, the change was limited to an editorial addition in language, which did not constitute a change in the physician work RVU.

Newly developed codes 78494 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* and 78496 *Cardiac blood pool imaging, gated equilibrium; single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)* were developed to provide for the reporting of various cardiac blood pool imaging processes. For 78494, the procedure is the same as that for CPT 78472, (*Cardiac blood pool imaging, gated equilibrium* RVU=.98), except that in addition, right ventricular function is studied more precisely by imaging the bolus of the radionuclide as it passes through the right ventricle. The physician services include review of the clinical record for indication for the procedure, supervision or performance of the injection, quality review of the processing of the data, visual review of the reformatted cine data, analysis and interpretation of regional and global right ventricular function, and incorporation of the results into the final consultation.

The RUC recommends a work RVU of 1.19 for code 78494. This recommendation is based on the work RVU for 78472 (.98) as a base, and the addition of the .21 as a value for the incremental physician work performed for this procedure. The recommended value also represents the median final value RVW weighted by the number of respondents from specialties.

Code 78496 is very similar to code 78481 *Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction with or without quantification* (work RVU=.98). The primary difference between these two codes is the technique by which the services are performed. Newly created 78496 does not use “first pass” technique. In addition, physicians are required to review multiple gated flow images. In determining a value for add-on code 78496, the RUC split the work RVU for 78481, and also divided the 78496 survey median (.98) for consistency. The work values for other add-on codes were additionally considered. It was the consensus that the work value was in between .49 and .62. Participants agreed that the survey median, .50, was appropriate, and accordingly, RUC recommends a work RVU of .50 for code 78496. The specialty has noted that this code will be rarely used as there are limited indications for this procedure (e.g. right ventricular dysfunction).

**Pulmonary Perfusion Imaging (Tab 28) Tracking Number LL1****Presentation: William Thorwarth Jr., MD, American College of Radiology, Kenneth A. McKusick, MD, Society of Nuclear Medicine**

A new CPT code was established to report pulmonary perfusion imaging with ventilation. The new code 78588 *Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, one or multiple projections* was previously reported with CPT codes, 78580 *Pulmonary perfusion imaging, particulate* (work RVU=.74) and 78587 *Pulmonary ventilation imaging, aerosol; multiple projections (eg, anterior, posterior, lateral views)* (work RVU=.49) for a total RVU of 1.23. 78588 is most similar to reference code 78585 *Pulmonary perfusion imaging, particulate with ventilation; rebreathing and washout, with or without single breath* (work RVU= 1.09). The RUC accepted the specialty recommendation of 1.09 RVUs for this procedure which is the 25<sup>th</sup> percentile of the survey results.

**Heliobacter Pylori Breath Test (Tab 29) Tracking Number PP1-PP2****Presentation: William Thorwarth Jr., MD, American College of Radiology, Kenneth A. McKusick, MD, Society of Nuclear Medicine**

Two new CPT codes, 83013 *Helicobacter pylori, breath test analysis;* and 83014, *Helicobacter pylori, breath test analysis; drug administration and sample collection,* were recently developed to reflect helicobacter breath test procedures. The RUC reviewed the CPT proposal and related information on the codes and decided that 83013 will be paid based on the Clinical Lab Payment Schedule. In addition, the RUC considered comments from various specialties who stated that both the drug administration and sample collection for the H pylori breath test are performed by nursing staff in the physician's office. Again, based on these remarks, the RUC concluded that no physician work was involved in these services, and therefore, does not recommend any Work RVU's. The specialty society did indicate that the nurse time is approximately 1 hour. The RUC recommends that 83013 be reimbursed on the Clinical Lab Payment Schedule and also that 83014 is performed by nursing staff and therefore no physician work is involved in this procedure.

**Intravascular Distal Blood Flow Velocity Measurements (Tab 30) Tracking Number U1-U2****Presentation: Presentation: James D. Maloney, American College of Cardiology**

Two new codes were established to report intravascular doppler velocity with pharmaceutical intervention, one or more vessels. The codes 93571 *Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)* and 93572 *each additional vessel (List separately in addition to code for primary procedure)*. The RUC

identified flaws in the survey data from the specialty society and has requested that a new survey be conducted for the September 1998 RUC meeting. The RUC recommends interim values based upon a building block methodology.

The relative values of two CPT codes that were recently reviewed by the RUC were also examined, 92978 *Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU=1.80) and 92979 *Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)* (work RVU=1.44). CPT codes 93571 and 93572 require more work than the intravascular ultrasound codes. For 93571, a catheter is placed in a normal vessel with baseline readings derived. The catheter is then moved to a pathological vessel. To determine the hemodynamic significance of the lesion, the doppler wire is passed across the lesion and baseline flow is measured. After adenosine intra-coronary injection, repeat flow and reserve measurements suggest that the lesion is not hemodynamically significant.

Accordingly, the RUC recommends a work value of 2.99 for 93571 which was calculated as follows:

92978 Intravascular ultrasound	1.80
93539 Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass	.40*
Normal vessel/ baseline determinations (2.20/2=1.10- 93931 .31)	<u>.79</u>
	2.99

\*This value includes injection of radiopharmaceutical and added risk of injection of an antiarrhythmic agent (adenosine)

The RUC recommends a work value of 1.70 for 93572 each additional vessel, which was calculated as follows:

92978 Intravascular ultrasound	1.80
Normal vessel/ baseline determinations (2.20/2=1.10- 93931 .31)	<u>.79</u>
	2.59
	<u>x50%</u>
	1.30

93539 Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass	<u>.40*</u>
	1.70

### **VIII. Practice Expense Subcommittee Report**

On April 30, 1998 the Practice Expense Subcommittee met to discuss the HCFA proposed practice expense regulation and to agree on the RUC's involvement in developing practice expense relative value recommendations. The following subcommittee members participated: Doctors Lichtenfeld (Chair); Gage; Hannenberg; Mayer; Molstad; Moorefield; Sigsbee; and Zwolak.

#### AMA Washington Report

Sharon McIlrath briefed the subcommittee on several recently published reports, which include; GAO; MEDPAC and HCFA. All three reports have examined the practice expense issue extensively. The report submitted to Congress by HCFA did indicate that it would take the GAO's recommendation to proceed with developing practice expense relative values but refining the methodology used by HCFA.

#### GAO Report

Bo Dee reported that Congress has requested the GAO to continue to examine the practice expense issue and report on the May HCFA NPRM.

#### MEDPAC Report

Kevin Hayes stated that MEDPAC plans to report on the proposed rule and is primarily interested in how it may impact access to care for certain geographical areas.

#### HCFA Update

Terry Kay provided an overview of the proposed practice expense methodology that will consist of two options. The first option will resemble the last proposal, which can be considered a bottom up approach, which begins with specific codes and seeks to build up all expenses associated with codes. The second approach, described in detail by Don Thompson is a significantly different cost allocation methodology which can be considered a top-down approach. This methodology seeks to aggregate practice cost data and then assign total costs to individual codes using the AMA's SMS survey data, the RUC/Harvard time data, and the CPEP data.

Doctor Bart McCann addressed the refinement process, which will last at least through 1999. HCFA will invite comments on extending this period for four years. Doctor McCann addressed multiple issues that will need to be addressed during this period.

#### Overview of the SMS Survey

Sara Thran and Kurt Gillis provided an overview of the AMA's Socioeconomic Monitoring System (SMS) survey. The AMA has conducted the random survey of non-

federal, patient care physicians since 1982. Although the survey collects data on seven categories of practice expenses the survey is designed to provide physician level practice expense data not practice level data.

#### AMA Legal Counsel Report

Ed Hirshfeld presented an analysis of the RUC-Practice Expense Antitrust issue. Mr. Hirshfeld concluded that if the RUC develops and disseminates recommendations to HCFA on the practice component of the RVRVS, it will not increase the antitrust liability of the RUC and does not violate federal antitrust laws.

After extensive discussion of the RUC's involvement in the development and refinement of practice expense relative value, the subcommittee made the following recommendation, which the RUC accepted:

**The RUC should play a role in refining and updating practice expense relative values, however, the specific role will not be decided until after closely examining the new HCFA Notice of Proposed Rulemaking.**

**The full Practice Expense Report is attached to these minutes.**

#### **IX. Research Subcommittee Report**

On April 30, 1998 the Research Subcommittee met to discuss the HCFA NPRM briefing which occurred during the Practice Expense Subcommittee meeting earlier in the morning and also to discuss the role of the RUC in the refinement process. The following subcommittee members were in attendance: Doctors Florin (Chair), Britton, Gee, Gerety, Koopman, Kwass, McCaffree, Taubman, and Eileen Sullivan-Marx, Ph.D.

##### Role of the RUC in the Refinement Process

The subcommittee focused its discussion around the use and possible refinement of the AMA SMS survey data. Several members expressed concerns about the SMS's sampling methodology and the possibility of the specialty society's role in submitting practice expense data to HCFA independent of the RUC to supplement the SMS data. Doctor McCann also talked about refinement of practice expense relative values and solicited comments on the RUC's role.

On May 1, 1998 the Research Subcommittee met again to discuss additional agenda items.

##### Review of Multi-Specialty Points of Comparison (IWPUT)

Doctor Florin stated that the overall goal of the research subcommittee regarding this issue is to improve the validity of the MPC so the RUC has accurate codes which can be considered reliable anchor points.

**The full Research Subcommittee Report is attached to these minutes.**

## **X. Rules and Procedures Subcommittee Report**

On April 30, 1998 the Rules and Procedures Subcommittee met to review the Committee's recent discussion regarding the RUC's role in the development of practice expense relative value recommendations. The following Subcommittee members participated in the discussion: Doctors Tudor (Chair), Berland, Collicott, Harer, Haynes, Winters, Whitten, and Emily Hill, PA-C.

### Revision of Revisions to the Rules and Procedures Document

The Committee made several revisions to the Rules and Procedures Document at the February 1998 RUC Meeting. The AMA Legal Counsel has reviewed and approved the initial changes and is prepared to review any additional changes. The Rules and Procedures Subcommittee made the following recommendations which were approved by the RUC:

**The Rules and Procedures Document should be revised as proposed in the attached document.**

**The full Rules and Procedures Report and the Revisions are attached to these minutes.**

### Rules and Procedures Subcommittee Report-May 1, 1998

#### Primary Areas of Concern with the PEAC

The subcommittee raised two significant concerns with the PEAC: 1) Should the PEAC exist at all? and 2) If it is warranted, what should be the composition of the PEAC?

After considerable discussion, the subcommittee made the following recommendations, which were approved by the RUC:

**The RUC chair will, if necessary, activate a Practice Expense Advisory Committee (PEAC). The RUC should consider the practice expense recommendations to be initially reviewed by the PEAC if necessary under the framework developed by the HCFA in the Final Rule. (See proposed revisions to Structure and Functions document).**

**The PEAC composition should include a Chair; the American Medical Association, and American Osteopathic Association; all 23 national medical societies with permanent or rotating seats on the RUC; one representative from the CPT Editorial**

**Panel, Health Care Professionals Association, the American Nurses Association, the American Academy of Physician Assistants, and five other non-MD/DO organizations.**

**The Full Rules and Procedures Committee Report is attached to these minutes.**

## **XI. Administrative Subcommittee Report**

On April 30, 1998, the Administrative Subcommittee met to discuss several administrative issues related to the Practice Expense Advisory Committee. The following members participated in the discussion: Doctors Rich (Chair), Hanley, Hayes, Hitzeman, and Vanchiere.

### Nominations for the Practice Expense Advisory Committee (PEAC)

It was agreed that members of the PEAC would be nominated and voted on by the RUC. It was suggested that individuals seeking nominations should meet at least one of the following standards which will serve as guidelines in the process: 1) Current or past member of the RUC, RUC Alternate, or current or past member of the RUC Advisory Committee; or 2) Participation in at least one of HCFA's events on practice expense including CPEP, October 1997 Validation Panels; or December 1997 Multi Specialty Panel; or 3) Demonstrated knowledge and expertise through significant involvement with their specialty society on the practice expense issue.

### Meeting Dates/Scheduling Issues for RUC involvement in the Development of Practice Expense Relative Values

After significant discussion, the majority of the committee members agreed that PEAC should be "piggy backed" onto the RUC meetings given the requirement for CPT code review and compilation and distribution of survey data. The committee also provided the RUC with a list of potential meeting sites.

**The full Administrative Report is attached to these minutes.**

## **XII. Other Issues**

The location for the September 1998 RUC meeting is pending. AMA meeting services is coordinating efforts and will provide location information to AMA staff as soon as possible (*staff note-the September 25-27, 1998 will be held at the Walt Disney World Hilton, Orlando, Florida*). It was noted that advance meeting planning (5-year) would be beneficial in terms of competitive housing prices and securing optimal locations.

### Specialty Requests for Review of RVUs

Terry Kay, HCFA clarified that requests from specialty societies to review existing relative values should be submitted directly to HCFA, with a copy sent to the AMA.

The following is a proposed timetable for the next 5-Year Review

- October 31, 1999- HCFA solicits comments for services to be reviewed in the next 5-Year Review
- September 2000- RUC submits recommendations
- January 1, 2002- Revised relative values are implemented

The Subcommittee discussed with Terry Kay the potential for reviewing these issues on an ongoing basis rather than in the aggregate during the 5-Year Review. In response, Terry Kay indicated that HCFA staff had been unable to devote resources to review specific issues due to their work on practice expense. In addition, HCFA has some concern regarding the ongoing budget neutrality adjustment other than that all at once in a Five-Year Review. He did indicate however, that HCFA needs greater specificity regarding the scope of the review and may consider suggestions to push back the comment period to October 31, 1998. The extension would then give the RUC two years to review the comments and submit recommendations to HCFA.

The RUC decided to study the methodology from the past Five-Year Review. In addition, the RUC will request that specialty societies forward a list of codes they consider misvalued to the AMA before the September 1998 RUC meeting. This list will be used for planning purposes only.

Doctor Koopman made several comments regarding the Five-Year Review that he would like addressed by HCFA before the next Five-Year Review. During the last review, the American Urological Association (AUA) and the American College of Radiology (ACR) were challenged by Carrier Medical Directors (CMDs) which required the associations to devote all their efforts into defending a majority of their codes. Devoting a great deal of resources to defend their services limited their ability to bring their undervalued codes to the RUC during the 5-Year Review. Doctors Koopman and Gee both requested that HCFA work directly with the CMD's to coordinate a more appropriate and diverse agenda to ensure fairness throughout the process.

Throughout this meeting, RUC members identified issues with the Multi-Specialty Points of Comparison (MPC). The RUC agreed that anomalies that exist within this list must be addressed before the next Five-Year Review.

**A motion was passed that the Research Subcommittee will review the MPC at the next RUC meeting in April**

Doctor Hoehn asked the RUC participants for their preference in meeting dates to discuss the NRPM. It was agreed that June 12, 11-5 that the RUC will meet in Chicago.

The meeting adjourned at 10:00 am.