AMA/Specialty RVS Update Committee
April 29-May 2,1999

Chicago Hilton and Towers
Chicago, IL

I. Call to Order:

Doctor Kay K.Hanley, called the meeting to order at 3:00 p.m. The following RUC members were in attendance:

Kay K.Hanley, MD
David Berland, MD
Joel Bradley, MD*
Melvin Britton, MD
John O. Gage, MD
William Gee, MD
Tracy R. Gordy, MD
Kay K. Hanley, MD
Alexander Hannenberg, MD
W. Benson Harer, MD
James Hayes, MD
Richard J. Haynes, MD
Emily Hill, PA-C
Charles Koopmann Jr., MD
Barbara Levy, MD*
J. Leonard Lichtenfeld, MD
William T. Maloney, MD*
David L. Massanari, ~~MD~~John Mayer, MD
John Mayer, MD
~~MD~~
David L.McCaffree,MD
Clay Molstad, MD
James Moorefield, MD
Eugene Ogrod, MD
William Rich, MD
Peter Sawchuk, MD*
Chester Schmidt, MD
Paul Schnur, MD
Bruce Sigsbee, MD
Sheldon B. Taubman, MD
Laura Tosi, MD*
Richard Whitten, MD*

*Alternate
The following individuals attended and were introduced by Doctor Hanley: Carolyn Mullen & Thomas Marciniak, MD, Health Care Financing Administration (HCFA); and William Mangold, MD, Carrier Medical Director of Arizona and Nevada.

II. Chair's Report:

Doctor Hanley announced that Doctor Hoehn will not be attending the RUC meeting and that she would be the Acting Chair in his absence. Doctor Hanley also announced that Sherry Smith will also be absent as she is on maternity leave and Patrick Gallagher would be serving as the Acting Director. Mr. Todd Klemp was introduced as a new Policy Associate for the Department of Relative Value Systems at the AMA.

Doctor Hanley reported that Doctor Charles Vanchiere recently had surgery and was doing fine and in very good spirits. Doctor Vanchiere was re-appointed by the American Academy of Pediatrics to serve another term on the RUC. The following representatives were also re-appointed by their specialty society: John Gage, MD; David Hitzeman, DO; J.Leonard Lichtenfeld, MD and Sheldon Taubman, MD.

III. Director's Report:

A Director's Report was presented by Patrick Gallagher, who announced the next RUC meeting will be held September 25-26 in Seattle, Washington. The PEAC is also scheduled to meet in Seattle on September 23-24, 1999. The February 2000 RUC meeting will be held in Phoenix, Arizona. The AMA is considering alternating future February RUC meeting's between the West Coast and Florida. All RUC participants were encouraged to share their meeting location preferences with Doctor Bill Rich, Chair of the RUC's Administrative Subcommittee.

IV. Approval of the September and November 1998 Minutes:

The minutes of the February 5-7, 1999 RUC meeting were approved after the following revisions were noted:

- Page One, Chairman's Report, the first sentence should read " Doctor Hoehn introduced Eugene Ogrod, MD as the new non-voting RUC member and Chair of the PEAC."

The minutes were approved as amended.

V. CPT Update:

Doctor Tracy Gordy, CPT representative to the RUC, provided an update on two upcoming meetings, the CPT Editorial Panel meeting to be held in mid-May 1999 and the CPT–5 meeting scheduled for June 3-5,1999. The CPT Editorial Panel will focus on reviewing the E/M Documentation Guidelines and it is therefore unlikely that the panel will be forwarding many coding changes to the RUC. However, the August CPT Editorial Panel meeting is expected to be very busy as it needs to review two large agenda books of coding proposals which will most likely be forwarded to the RUC for consideration at its September meeting.

Doctor Gordy provided the RUC with an overview of the CPT-5 project. The goal of the CPT –5 project is to make CPT much more user friendly while complying with Health Insurance Portability and Accountability Act (HIPPA) Regulations. This will allow CPT to be competitive in the market and remain the predominant coding system in the United States.

The CPT-5 workgroups are expected to meet through November 1999. However, several of the workgroups including Research, Site of Service, and Non-Physician workgroup have completed their charge. Doctor Gordy reported that the Non-Physician Workgroup has requested that the Panel approve a framework that will be used in the development of coding proposals for Evaluation and Assessment services. The need for Evaluation and Assessment codes was established following a survey that was distributed by non-physician providers last fall.

The Executive Project Advisory Group (PAG) submitted over fifty-two recommendations to the Editorial Panel. Twenty-three of those recommendations were submitted for the Panels "action"and, if accepted, fall within the scope of changing the way the Panel develops new codes and will revise the language of existing CPT codes. Whereas, the other twenty-nine recommendations submitted are for the Panels consideration only. Doctor Gordy explained that although the Panel considers the recommendations, it is really the responsibility of the AMA to accept or reject these recommendations.

Doctor Gordy explained that it is still unclear how CPT-5 will handle the Global Surgical Package. Three of the workgroups recommended the elimination of the Global Surgical Package. However, the issue has been tabled pending the collection of information on the following two questions: 1) should the intra procedural or intra operative period be considered a separate, distinct package of services and what if any, pre and post work should be attached to compromise the global package; 2) deletion of site specific E/M categories and use of the site of service field on HCFA 1500 for determining reimbursement.

Doctor Gee, a PAG representative, requested that the RUC reach a consensus on the Global Surgical Issue so he may adequately represent the RUC's interests during the PAG's deliberations. The RUC unanimously agreed that they did not have enough information on the potential implications of the elimination of global surgical packages for the RUC to respond. However, the RUC will look forward to reviewing the PAG's recommendations to the Panel on this issue. This does not preclude specialty societies from making their own inputs known to the PAG.

VI. Correct Coding Initiative Update:

Doctor Kenneth McKusick, Chair of the Correct Coding Policy Committee (CCPC) gave an overview of the Committee's most recent activities and correct coding efforts.

Summary of March 3, 1999 Meeting

Since the last report to the RUC, the CCPC met in Chicago to review two separate reports at the request of HCFA. The first report dealt with comments from specialty societies regarding Phase IV of the Correct Coding Initiative. Doctor McKusick explained that the comments were limited in scope to those code pairs that had received what is called an Action Key #3 designation which means that a code pair edit should be eliminated from use based upon a specific, clinical rationale. The second report set forth the parameters but related to a different set of coding edits proposed by Carrier Medical Directors that were reviewed by specialties in January 1999.

Due to the nature of the March 3 Meeting and review, several individuals, primarily specialty society staff, were invited to participate at the request of AMA. During the meeting, members and other staff were provided an opportunity to answer questions posed by HCFA and to clarify previous responses on code pair edits. In addition, on April 1[s] the CCPC forwarded a comprehensive written report that included additional rationale and supporting recommendations calling for deletions of hundreds of CCI edits. Doctor McKusick also

reported that members of the CCPC were very pleased to to welcome a new addition to the CCPC, Karl E. Becker, MD who represents the American Society of Anesthesiologists, and also serves as an Advisory Committee member on the RUC.

HBO & Company Follow-Up

HBOC continues to send black box edits to HCFA. Last November, the CCPC members reviewed confidential edits in use by HCFA. Doctor McKusick explained that these edits have been purchased by McKesson HBO & Company. In January 1999, the CCPC's written analysis was delivered to HCFA. At this same time, several Carrier Medical Directors has also challenged a large number of these edits. As a result, nearly 90 edits were eliminated from use of January 1, 1999.

Doctor McKusick reported that although the CCPC has not received a formal response from Doctor Berenson, HCFA staff recently provided the AMA with an update of the 214 edits which have been reviewed by the committee including: 1) All edits pertaining to the destruction of lesions and surgical pathology have been deleted; 2) All code pairs that included the CPT code 47001 *Biopsy of liver* have been eliminated; and 3) Overall, HCFA stated they agreed with with 167 of the responses submitted by the CCPC, and as a result of the CCPC's careful analysis, the HCFA has retracted approximately 79 code pairs from use. A final, formal response from HCFA regarding their observations is expected in early May.

Additionally, in March of this year, HCFA made a subsequent request to the CCPC for another review of approximately 180 other edits. Again, all edits were reviewed under an agreement of confidentialty. In this instances, the edits are not expected to be implemented until July 1999. The CCPC will deliver a report to HCFA on April 30th, detailing the acceptability and/or inappropriateness of this series of coding editing.

Future Meetings

The CCPC will postpone its previously scheduled June 1999 meeting, and will meet next on August 25, 1999. A report of that meeting will be provided to the RUC at the September RUC meeting in Seattle, Washington.

The RUC expressed their sincere gratitude for the CCPC's efforts over the years.

VII. HCFA Update:

Doctor Thomas Marciniak provided an update on HCFA's recent activities related to the Year 2000 (Y2K) issue, practice expense, five-year review, the development of resource-based malpractice relative values and its ambulatory surgical center regulation.

Doctor Marciniak reported that physician fee schedule updates will be updated January 1, 2000. However, the only variation is that HCFA will hold claims until January 17th and will

then resume processing claims. This is not drastically different than what is ordinarily done since by statute, HCFA is required to hold claims for two weeks.

The PEAC has demonstrated to HCFA that progress can be made on this issue according to Doctor Marciniak. HCFA is prepared to implement all PEAC recommendations and physician time data that are well documented and justified and received by July 1,1999. HCFA will still consider those recommendations received after July 1 but due to budgetary constraints, HCFA cannot guarantee that they will be implemented into the November 2, 1999 Final Rule.

The National Proposed Rulemaking (NPRM) is scheduled to be released early June and will include: 1) practice expense issues; 2) leftover code issues from the September 1999 RUC meeting; and 3) information on Malpractice/Physician Liability Insurance relative values.

The Final Rule is scheduled to be released in early November and will also have details on code level practice expense that could be set forth by the PEAC, and how to address the next five-year review. HCFA plans on hiring technical contractors early summer, to provide advice on practice expense refinement issue. HCFA has stated that they could not provide more specifics on refinement until they selected a contractor.

VIII. HCPAC Report

Emily Hill, PA-C announced that both her and Steve Levine's term as HCPAC Co-Chair and Co-Chair Alternate expire following this meeting. However, Ms. Hill will continue to serve as the HCPAC representative for the American Academy of Physician Assistants. Ms. Hill announced that the HCPAC elected Don Williamson, OD as the new HCPAC Co-Chair and Eileen Sullivan Marx, PhD as the Co-Chair Alternate.

Ms. Hill also reported that the HCPAC shares similar concerns voiced by many RUC participants about the PEAC and hopes that many of these issues will be resolved soon. Ms. Hill explained that Doctor Gordy's CPT-5 update on the recommendations sent to the CPT Editorial Panel caught many HCPAC participants by surprise. Although, the HCPAC supports allowing more access and definition of services by non-physicians in CPT, there is considerable concern about the wording of the recommendations and the implications for those members who currently have access to CPT codes, as well as the impact on budget neutrality. Finally, the HCPAC discussed several ways to convey their concerns to the CPT Editorial Panel and agreed to the following:

The RUC HCPAC would produce a collective letter encompassing their concerns which would be forwarded to the Chair of the CPT Editorial Panel.

The approved HCPAC Report is attached to these minutes.

IX. Election of the RUC Rotating Seats

The following individuals were nominated for the two RUC Internal Medicine Rotating Seats:

Joel Brill, MD	American Gastroenterological Association
Alan Plummer, MD	American Thoracic Society
David Regan, MD	American Society of Clinical Oncology
Samuel Silver, Md, PhD	American Society of Hematology

The following individuals were nominated for the Any Other Rotating Seat:

Daniel Ein, MD	Joint Council of Allergy, Asthma, and Immunology
Lanny Garvar, MD	American Dental Association
Bernard Pfeifer, MD	North American Spine Society
Anthony Senagore, MD,MBA	The American Society of Colon and Rectal Surgeons
Robert Vogelzang, MD	Society of Cardiovascular & Interventional
Elaine Wagner, MD	American Society of Cytopathology
Paul E.Wallner, DO	American Society for Therapeutic Radiology & Oncology
Michael A. Wilson,MD	Society of Nuclear Medicine
Robert M.Zwolak, MD	North American Chapter International Society for Cardiovascular Surgery *and* The Society for Vascular Surgery

Several RUC participants expressed concern that the two Internal Medicine seats would rotate off at the same time and suggested the RUC consider staggering these seats. The RUC proposed that each of the candidates provide a brief description of their qualifications for the rotating seats. However, not all the candidates were present so the RUC approved the following motions:

The RUC vote for candidates will be based upon the information in the agenda book only.

The Administrative Subcommittee should review the following: appropriate materials necessary for elections held in the future; consideration of the balloting processes and the possibility of staggering the two Internal Medicine rotating seats.

The RUC selected Alan Plummer, MD and David Regan, MD to the Internal Medicine Rotating seat and Robert M. Zwolak, MD to the other rotating seat.

X. Relative Value Recommendations for New & Revised Codes for CPT 2000

A. Allergy Immunotherapy Injection (Tab 5) Tracking Numbers I1-I4

The Joint Council of Allergy, Asthma and Immunology (JCAAI) and the American Academy of Otolaryngic Allergy (AAOA), withdrew this issue and requested that the AMA RUC not consider these issues until further request by these organizations.

B. Integumentary System Repair (Tab 6) Tracking Numbers A1-A-4
Presentation: Paul Schnur, MD, American Society of Plastic and Reconstructive Surgeons

A facilitation committee Doctors Moldstad (Chair), Busis, Gordy, Koopman, Lichtenfeld, Massanari, Mayer, Winters, and Lenet (DPM) met to consider this issue.

A series of four new add-on codes 13102, 13122, 13133 and 13153 was adopted to describe complex repair for each additional 5 cm or less by anatomic site. The following changes were implemented: 13102 *Repair, complex, trunk; each additional 5cm or less;* 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less;* 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5cm or less;* and 13153 *Repair, complex, eyelids, nose, ears, and/or lips; each additional 5cm or less*. These new add-on codes allow for the quantification of the additional work performed for repairs over 7.5 cm in length. Since the amount of work for each group of repairs is progressively greater, a separate add-on for each group of repairs is necessary. These codes will replace the deleted single code 13300, *Repair, unusual, complicated, over 7.5 cm, any area* (work RVW=5.27).

The RUC valued the codes using the same methodology used by Carrier Medical Directors (CMDs) during the Five-Year Review in 1997. During this review, CMDs increased the work RVW of CPT Code 13132 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm* from 3.79 to 5.95 (an approximate increase of 55%). While reviewing values for these newly established add-on codes, the RUC recommended lowering the specialty society suggested values by 55%. The new values adequately account for the additional work involved in each of these codes and also avoid the potential for a rank order anomaly within the family of codes. Therefore, the RUC supports the following recommended RVUs:

Work Relative Value Recommendation: The RUC recommends a work relative value of 1.24 for 13102; a work relative value of 1.44 for 13122; a work relative value of 2.19 for 13133; and finally, a work relative value of 2.38 for 13153.

Practice Expense Recommendation: The RUC is not making any practice expense recommendations for these codes. The RUC agreed to table the practice expense recommendations since it was not able to fully evaluate the specialties' recommended crosswalk for these codes.

C. Pacing Cardioverter-Defibrillator Pacemaker Systems (Tab 7) Tracking Numbers B1-B6
Presentation Doctor Steve Hammill, American College of Cardiology

Several editorial and substantive changes were adopted by the CPT Editorial Panel for inclusion in CPT 2000. CPT codes that report services related to the implantation of pacing cardioverter-defibrillator generators. As a result of these changes, the RUC examined physician work relative values for two CPT codes within this section. The changes to the

descriptor language necessitated a review of these codes. All other modifications were considered editorial by physicians. However, they have been included in the summary as a reference tool.

CPT Code 33244

CPT code 33244 was revised in part to describe *Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by transvenous extraction.* The physician work associated with CPT code 33244 had been valued at 8.97.

In developing an appropriate work relative value unit for the revised code, the RUC backed out 3.24 rvu's from the proposed rvu of 17.00 presented in the survey data. The value of 3.24 represents the physician work associated with a generator removal (CPT code 33241 *Removal of implantable cardioverter defibrillator pulse generator only,* work rvu = 3.24). It is expected that CPT code 33241 will also be billed with 33244.
The proposed rvw of 17.00 was the median survey value derived from specialty society's surveys. The RUC reasoned that surveyed physicians did not consider that 33241 would be separately coded, and that they included the physician work of 33241 in their estimate of the work for revised code 33244.

As such, RUC members reached a consensus that 13.76 was an appropriate work relative value unit for the revised CPT code.

CPT Code 33249

CPT code 33249 was modified for CPT 2000 to report *Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator*. The physician work value assigned to this code previously was 13.28.

In considering the work involved in the new descriptor for CPT 33249, the RUC used a building block methodology to determine a new relative value unit. It was noted that the primary procedure is the insertion of leads (CPT 33247 *Insertion or replacement of implantable cardioverter-defibrillator lead(s), by other than thoracotomy*, work RVU = 10.21). The RUC added one-half the value of the implantation of a single chamber device plus an additional lead (CPT 33207 *Insertion or replacement of permanent pacemaker with transvenous electrodes* work, work rvu= 8.04) to arrive at a total work RVU of 14.23. The RUC agreed that the additional work of another chamber and lead justified an increased work rvu. As such, the RUC supports adoption of 14.23 as the new rvu for revised CPT code 33249.

<u>Work Relative Value Recommendations:</u> The RUC supports a work relative value recommendation of 13.76 for CPT code 33244 and 14.23 for CPT code 33249.

<u>Practice Expense Recommendations:</u> No practice expense data was presented for these revised codes. As such, the RUC does not have any formal recommendations at this time.

D. Implantation and Removal of Cardiac Event Recorder (Tab 8) Tracking Numbers U1-U3 Presentation SteveB5-B8
Presentation: Steve Hammill, MD, American College of Cardiology

A series of new codes was established to report implantation and removal of a patient-activated cardiac event recorder as well as implantable loop recorder (ILR) reprogramming. The ILR represents new technology that is capable of extending the cardiac monitoring period sufficiently to address infrequent, recurrent symptoms. There is no code currently assigned to these procedures. Although the ILR appears to have similar components and the insertion or replacement of this device appear procedurally similar to that of a pacemaker pulse generator CPT 33212 *Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular* (work RVU = 5.52), and CPT 33233 *Removal of permanent pacemaker pulse generator* (work RVU = 3.29), the nomenclature does not accurately describe ILR implantation.

CPT Code 33282

The RUC compared the total physician work time for the new code 33282 *Implantation of patient-activated cardiac event recorder* (150 minutes) to that of 1994 survey data for the reference procedure CPT Code 33212 (180 minutes). Based on the survey data, it was agreed that the new procedure has 17% less total service time than the time reported in the reference procedure's survey data. Reducing the reference code's RVW (5.52) by the same percentage arrives at a work RVW of 4.6. The 4.6 RVW was then adjusted to reflect the greater intensity of the 33212's intra-service time to arrive at a final recommendation of 4.17 for CPT 33282.

CPT Code 33284

The RUC compared the total time involved in the new code 33284 *Removal of an implantable, patient-activated cardiac event recorder* (90 minutes) to the 1994 survey data for 33233(105 minutes) and agreed that CPT 33284 was 24% less work. The RUC concluded that the new code's RVW should be 24% less of 33233's RVW of 3.29. As such, the RUC recommended 2.50 for 33284.

CPT Code 93727

The RUC recommends an RVU of 0.52 for 93727 Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and programming).

This recommendation appears appropriate as the time and intensity of two comparable procedures, CPT 93224 *Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual supeimposition scanning; includes recording, scanning analysis with report, physician review and interpretation,* and 93230 *Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation.* Both of these procedures have RVWs of 0.52. The recommendation of 0.52 also represents the 25th percentile of the survey results.

Work Relative Value Recommendations: The RUC supports the following work relative value units: CPT Code 33282-4.17; CPT Code 33284-2.5; and .52 for 93727.

Practice Expense Recommendations: The RUC's discussion of practice expense for these particular codes was very limited as the specialty society did not submit practice expense information. As such, the RUC is unable to make a final recommendation regarding practice expense at this time.

E. Vision Screening (Tab 9) Tracking Number)O1
Presentation: Doctor Steven Krug, American Academy of Pediatrics

A new CPT code 92961 *Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)* was established to describe an effective therapy for patients unresponsive to external cardioversion. Although cardioversion does not reflect new technology, advancements in catheter technology and techniques have greatly increased the efficacy and applicability of this procedure. Currently, this procedure is being reported using codes 92960 *Cardioversion, elective, electrical conversion or arrhythmia, external* (work RVW=2.25) plus 93602 *Intra-atrial recording* (work RVW=2.12) plus 93603 *Right ventricular recording* (work RVW=2.12) with appropriate modifiers. These codes are inadequate as intracardiac cardioversion is quite different from external cardioversion in that intracardiac cardioversion requires vascular access, placement of catheters into the heart under fluoroscopy, and a much greater knowledge of electrophysiology procedures. Therefore, the physician work, risk and practice expense of intracardiac conversion are significantly greater than for external cardioversion.. Therefore, the RUC accepted the specialty society's recommendation of 4.6, which is the final median RVW for CPT code 92961.

Work Relative Value Recommendation: The RUC supports a work relative value unit of 4.6 for CPT code 92961.

Practice Expense Recommendation: The specialty society did not offer any recommendations regarding direct practice expense inputs for this code. As such, the RUC is not making a practice expense recommendation for this code.

F. Colposcopy/Androscopy (Tab 10) Tracking Number P1
Presentation: Doctor Steve Krug, Amercian Academy of Pediatrics

A new CPT code, 99170, was created to describe *Anogenital examination with colposcopic magnification in childhood for suspected trauma.* The work involved in using a colposcope in young female and male suspected sexual abuse victims had previously been included in the Evaluation and Management Services. The RUC heard compelling evidence regarding the extensive work and intensity involved in providing this service such as the lengthy process of positioning the child to allow a complete inspection. Since the child often does not remain still, the colposcope must be refocused, the child must be repositioned, and the result is an increase in time required for the examination. Additionally, the implications of making the wrong decision based on the evidence collected during this procedure are quite serious and also contribute to the increased time necessary to perform the procedure and document the findings. The RUC examined the median reported time of 50 minutes and the results of the intensity/complexity measures contained in the summary of recommendation form and agreed that the recommended RVU accurately reflects the level of work involved. The RUC therefore recommends the work RVU of 1.75.

Work Relative Value Recommendations: The RUC supports a work value recommendation of 1.75 for CPT Code

Practice Expense Recommendations: The RUC tabled discussion of the practice expense direct inputs submitted by the specialty society. The RUC was concerned that the clinical staff recommended times needed further review by the specialty society. The RUC is therefore not forwarding direct input data for this code.

G. Immunization Administration (Tab 11) Tracking Numbers CC1-CC2
Presentation: Doctor Steve Krug, American Academy of Pediatrics

Code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid),* and code 90472 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid)* were both editorially revised to more accurately reflect the work associated with administering vaccines. These changes were made so that the resources and work required to administer multiple vaccines would be more accurately identified and also to more accurately track the costs of administering immunizations.

While the specialty presented its median survey RVW as the recommended RVW, the RUC reviewed this recommendation and concluded that the RVW was too high since immunization administration is typically performed in conjunction with a evaluation and management code. The RUC concluded that the work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. To maintain the originally proposed relativity between the administration of the first vaccine and each additional vaccine (which was .02 RVW's lower), the RUC recommended reducing 90472 by .02 RVUs, for a final recommended RVU of .15. The RUC therefore recommends a work RVU recommendation of .17 for code 90471 and an RVU of .15 for code 90472.

Work Relative Value Recommendation: The RUC supports a work RVU recommendation of .17 for code 90471 and an RVU of .15 for code 90472.

Practice Expense Recommendations: The RUC examined the direct inputs associated with immunization administration and added " Xerox copy" as an additional supply item to both 90471 and 90472 to reflect the cost of documenting the immunization for public health purposes. The RUC discussed the marginal costs involved in code 90472 and agreed to reduce the clinical staff time to two minutes. The RUC decided that the time to provide an additional immunization was only two minutes, substantially lower than the time required to provide the first immunization.

H. Prostate Volume Study (Tab 12) Tracking Number N1
Presentation: Thomas P.Cooper,MD,American Urological Association

A new CPT Code, 76873 *Echography, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)*, was developed to more accurately describe mapping the prostate and plan seed prostate weeks prior to the interstitial radioactive seed placement. This procedure is currently being reported using 76872 *Echography, transrectal* (work RVU= .69). This reporting is inadequate since it does not capture the extensive work involved in the planning for a prostate volume study for brachytherapy treatment.

In determining a work relative value for this procedure, the RUC considered a range of values: 1.86 to 2.10. To achieve this range, the RUC combined the work value of CPT code 92018 *Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete* (work RVU= 1.51) and ½ the work value of CPT code 76872 (work RVU= .69). (.69 x .5 = .35 + 1.51 =1.86). Next, the RUC combined the work relative value of CPT 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU= 1.57) and ½ the work value of CPT code 76872 (work RVU=.69 (.69 x .5 = .35 + 1.57 = 1.92.) Finally, the RUC combined the work value of CPT code 57410 *Pelvic exam under anesthesia* (work RVU = 1.75 and ½ the work value of CPT code 76872 (.69 x.5 = .35 + 1.75 = 2.10). Using this range, the RUC reached a consensus that the work relative value of 1.92.

Work Relative Value Recommendation: The RUC supports a work relative value of 1.92 for CPT Code 76873.

Practice Expense Recommendation: The direct inputs for this code were developed by a consensus panel which estimated clinical staff time, supplies and equipment required to perform this service in both the facility and non facility settings. The only direct inputs in the facility setting is the clinical staff time of 60 minutes for patient education and pre-certification, and arranging to schedule the patient in the facility. When this service is provided in the non-facility setting, the preservice clinical staff time is reduced to 35 minutes, but there is clinical staff time in the intra-service and post-service categories as well as supply and equipment expenses. See attached direct input data.

I. Laparoscopic Urological Procedures (Tab 13) Tracking Numbers Z1-Z8 Presentation: Thomas P. Cooper, MD, American Urological Association

CPT Code 50541

Newly created CPT code 50541 *Laparascopy, surgical; ablation of renal cysts* was developed to describe new technology in this area of medical services. The technology of laparoscopy provides a minimal incision to drain and ablate the cyst wall. The new technology also spares the patient a large incision. The procedure is currently coded using CPT code 53899 *Unlisted procedure, urinary system.*

When evaluating the physician work, RUC members agreed that the physician work was similar to CPT code *50280 Excision or unroofing of cyst(s) of kidney* (work RVU =15.67) and used this as a reference. In addition, they also considered the survey median of 16.00. Based on their discussion, the RUC agreed that a work RVU of 16.00 was appropriate.

CPT Code 50544

CPT code 50544 *Laparoscopy, surgical; pyeloplasty* was developed to reflect new laparoscopic technology in use, similar to the previous code. Laparoscopic techniques have evolved, and currently allow for treatment of this and other conditions without necessitating a large incision. The procedure has been performed for nearly five years and is reported under CPT code 53899. By using the unlisted procedure, it fails to capture the technical aspect of the surgery. There are no codes for laparoscopic pyeloplasty.

In considering proposed work relative value units, the RUC referred to the reference code used in the survey, particularly CPT code 50400 *Pyeloplasty, (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting simple* (work RVU = 19.5). The RUC also relied on survey data, and agreed that the survey median was an appropriate valuation of physician work. The RUC therefore recommends a physician work rvu of 22.40.

CPT Code 50546

A new code was adopted (CPT 50546) for use in CPT 2000 to report Laparoscopy, surgical; nephrectomy. Laparoscopy has evolved over the past five years to allow for minimally invasive removal of the kidney and ureter. The procedure has been reported for the past five years under CPT code 53899 *Unlisted procedure, urinary system.* The laparoscopic procedures require different instrumentation and procedural steps to safely remove the kidney. There are currently codes for open nephrectomy, but none for laparoscopic.

In considering potential work relative values, the RUC reviewed and referenced CPT code 50220 *Nephrectomy, including partial ureterectomy, any approach using rib section* (work rvu= 17.15), and noted differences in time and intensity for the new procedure. The RUC agreed that the survey median of 20.48 was an appropriate final value for the new code.

CPT Code 50548

CPT also approved a fourth code in this series for inclusion in CPT 2000. CPT 50548 was created to report *Laparoscopically assisted nephroureterectomy.* As with previous codes, no codes currently exist to report the new technology. At present, physicians currently report this procedure by using CPT 53899.

In proposing a final work relative value unit, the RUC noted CPT code 50234 *Nephrectomy with total ureterectomy and bladder cuff; through same incision* (work rvu= 22.40). RUC members agreed that the physician time and related data was extremely similar to this

procedure. They also considered the survey median and agreed that the median RVW was appropriate. The RUC recommends a work relative unit of 24.40 for newly adopted code 50548.

CPT Code 50945

CPT code 50945 was constructed to describe *Laparoscopy, surgical; ureterolithotomy.* These services are currently reported under CPT 53899. The new code incorporates and captures the technical aspects of the laparoscopic procedure. As with the previous codes in the urinary system, there are no codes that capture this information.

In considering proposed physician work relative values, the RUC reviewed survey data and also examined the reference code of CPT 50610 *Ureterolithotomy, upper one-third of ureter* (work RVU= 15.92). The RUC also examined survey results and various responses regarding physician work. The RUC agreed that the survey median of 17.00 was an appropriate value.

CPT Code 51990

Another CPT code (51990) was adopted to report *Laparoscopy, surgical; urethral suspension for stress incontinence.*The services are currently reported under 58999 *Unlisted procedure, female genital surgery.*

The RUC considered the responses presented by various specialties regarding time, intensity, and complexity measures. It was the consensus of the RUC that a work relative value 12.5 accurately represented the physician work involved in the laparoscopic procedure. The value of 12.5 also represents the survey median.

CPT Code 51992

CPT code 51992 *Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)* was adopted for inclusion in CPT 2000. The code was implemented in order for the technique to be captured in the new code.

In formulating its recommendation for physician work, the RUC reviewed reference code 57288 *Sling operation for stress incontinence (fascia or synthetic)* (work RVU= 13.02) and also considered median rvw adopted from the survey results.

Noting the differences in the laparoscopic approach to the procedure, the RUC agreed the survey median of 14.01 adequately represented the physician work involved in the procedure.

CPT Code 54692

Currently coded under CPT 55899 *Unlisted procedure, Urinary Male Genital System,* newly created CPT Code 54692 *Laparoscopy, surgical; ochiopexy for intra-abdominal testis* was adopted for inclusion in CPT 2000 . As previously noted throughout this section, the new code describes laparoscopic orchiopexy. When performing this procedure laparoscopically, the laparoscope allows for the magnification of minute blood vessels. Laparoscopic procedures have evolved with respect to these services. The services described under the new codes that have been utilized for nearly five years.

Similar to the previous code, the RUC referenced procedures 54650 *Orchiopexy, abdominal approach, for intrabdominal testis (eg Fowler-Stephens)*(work RVU=11.45). In addition, the RUC also evaluated the survey data and agreed that the survey median of 12.88 was an accurate value representing physician work.

Work Relative Value Recommendations: The RUC supports the following recommendations, CPT code 50541-16.00, CPT code 50544- 22.40, 50546-20.48, 50945-17.00, 51990-12.50, 51992-14.01, and 54692-12.88.

Practice Expense Recommendations: The direct inputs for these codes were developed by a consensus panel which estimated clinical staff time, supplies and equipment required to perform this service in only the facility settings. The RUC accepted the direct inputs listed as representative of the expenses incurred in providing these services. The RUC agreed that the direct inputs for these codes are very similar with some variation in clinical staff time and only minor differences in supplies. Although the physician work varies to a much greater extent for these codes, the direct inputs do not have the same differences among these codes. See attached direct input data.

J. Spine Surgery (Tab 14) Tracking Number J1-J2
Presentation: Doctors Gregory Przybylski, American Association of Neurological Surgeons/ Congress of Neurological Surgeons; Thomas Faciszewski, North American Spine Society; Peter Dempsey, American Association of Neurological Surgeons

New CPT codes were added to describe a method for anterior instrumentation and stabilization of odontoid fracture/dislocation. Since the odontoid process is an extension of the axis, rather than an interspace or two adjacent vertebral segments, the current arthrodesis code 22548 *Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process* (work RVU= 25.82) does not accurately describe the reduction and internal fixation across a fracture within a single vertebral.

CPT Code 22318

The RUC recommends that CPT Code 22318 *Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting* be assigned a work value of 21.50. The value of 21.50 was the survey median. This value was based on a survey of 43 neurological and orthopaedic surgeons. CPT Code 22318 utilizes the same initial surgical approach as 63075 *Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* (work RVU= 19.41). The remainder of 63075 describes diskectomy and microdissection with a microscope or direct visualization. In contrast, 22318 describes the sequential placement of guidewires and screws without direct visualization using flouroscopic guidance. The greater time required for positioning the patient and preparing equipment for CPT Code 22318 (120 minutes pre-service), compared to 63075 (76 minutes pre-service), further justifies the recommended RVU of 21.50 for 22318.

CPT Code 22319

The RUC supports a work RVU of 24.00 for CPT Code 22319 *Open treatment and/or reduction of odontoid fracture (s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting*. The difference between 22318 and 22319 is the placement of the graft. The additional rostral exposure of the anterior surface of the odontoid process and decortification of fracture surfaces entails additional time and risk. Also, securing the placement of the graft requires more time, making code 22319 more complex. Therefore, the RUC recommends that 22319 be assigned a work RVU of 24.00. This value is also the survey median.

Work Relative Value Recommendation: The RUC supports a work relative of 24.00 for CPT Code 22319 and 21.50 for CPT Code 22318.

Practice Expense Recommendations:
CPT Code 22318

Since this is a new code, there is currently no direct input data associated with the code. The specialties chose to crosswalk this code to an existing code, which has direct inputs that the specialty believes is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 63075 *Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace* should be applied to code 22318.

CPT Code 22319

Since this is new code, there is currently no direct input data associated with the code. The specialties chose to crosswalk this code to an existing code, which has direct inputs that the specialty believes is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with 22548 *Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process* should be applied to code 22319.

K. Epidural or Subarachnoid Spine Injection Procedures (Tab 15) K1-K5

Presentation: Doctors William Thorwarth Jr., MD, American College of Radiology and J. Arliss Pollock, MD, American Society of Nuclear Medicine.

New codes 62310 –62319 were developed to systematically organize different routes for injection (subarachnoid, epidural), at different levels (cervical, thoracic, lumbar, caudal), for different substances (narcotic, anesthetic, steroid, antispasmodic).

The most difficult of these four procedures is 62318, followed by 62310 and 62319 (approximately equal), and then 62311. Nine current CPT codes were deleted and crosswalked into these four new codes. Additionally, three of the codes include procedures that did not have specific codes assigned: 62310 now includes injection, epidural, cervical of steroid or narcotic; 62318 now includes infusion, epidural, cervical antispasmodic, narcotic or steroid; and 62319 now includes infusion, epidural, lumbar of steroid. It should also be noted that with respect to this code series, the Harvard post-service data for each of the nine codes being deleted was predicted at 7 to 9 minutes. These services, whether performed in a facility or non-facility, will require frequent post service monitoring of the patient and discharge management. The survey median post-service time for four of the codes (62310 - 62319) ranges from 15-30 minutes, which is two to three times more than Harvard's predicted estimates. Harvard's pre-service time is also lower by 5 to 15 minutes. Harvard's intra service time is only slightly lower than the new codes.

CPT Code 62310

CPT Code 62310 was created to report *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic.*

The survey median of 2.20 is recommended for 62310. This is the current RVU for deleted code 62298, most closely related to the new code as it is used in current practice. The RVW is slightly more than the other three codes (62274, 62275, 62288) being crosswalked to this new code, but less than the amount of work for the cervical procedures, which previously would have been coded using 64999. The RUC agreed that the survey median represented a fair balance of the portions of all codes combined.

<u>CPT Code 62311</u>

The CPT Editorial Panel adopted 62311 to describe *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal).*

The survey median of 1.78 is recommended for CPT code 62311. This is the current value for deleted code 62274, which has time and intensity/complexity measure closely related to the

new code. The second referenced code 62278 has lower time and intensity/complexity measures across the board as compared with the new code 62311.

CPT Code 62318

Also appearing in CPT 2000 will be CPT code 62318, which reports *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic.*

The survey median of 2.35 is recommended for 62318. This is slightly more than the current values for deleted crosswalked codes 62276 and 62277, but less than the amount of work for the cervical procedure, which is previously would have been coded using 64999. The RUC supported the survey median and agreed that the value of 2.35 represents a fair balance of the portions of all codes combined for this infrequently performed procedure.

CPT Code 62319

Within this series, CPT Code 62319 was developed: *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal).*

The survey median of 2.15 is recommended for 62319. This is the current value for deleted CPT code 62227 and most closely relates to the new code as it is used in current practice, but less than the amount of work for the cervical procedures, which previously would have been code using 64999. The second referenced 62279 has lower time and intensity/complexity measures across the board a compared with new code 62319. The RUC agrees that the survey median represents a fair balance of the portions of all codes combined.

CPT Code 72275

Also implemented as a change for CPT 2000 was adoption of a new code to reflect *Epidurography, radiological supervision and interpretation.* This code was developed to allow for the reporting of radiologic component of epidurography

In evaluating potential relative work value units, the RUC referenced CPT code *72265 Myelography, lumbosacral, radiological supervision and interpretation* (work RVU=.83) and also considered survey results. The RUC recommends the median survey value, .83, which is also the same value as the key reference code, though the intensity and complexity values are consistently slightly higher.

Work Relative Recommendations: The RUC supports the following work relative value recommendations: CPT code 62318-2.35, 62310-2.20, 62319-2.15, 62311-1.78, and 72265-.83.

Practice Expense Recommendations:

Since these are new codes there currently are no direct input data assigned to these codes. The specialties chose to crosswalk these codes to existing codes with direct inputs that the specialty believes is representative of the expenses associated with the new codes.

CPT Code 62310
The RUC recommends that the direct inputs associated with code 62298 *Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural, cervical or thoracic (separate procedure*) be applied to code 62310.

CPT Code 62311
The RUC recommends that the direct inputs associated with code 62289 *Injection of substance other than anesthetic, antispasmodic, contrast, or neurolytic solutions;lumbar or caudal epidural (separate procedure)* be applied to code 62311.

CPT Code 62318
The RUC recommends that the direct inputs associated with code 62277 *Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics);subarachnoid or subdural, continuous* be applied to code 62318.

CPT Code 62319
The RUC recommends that the direct inputs associated with code 62277 *Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics);subarachnoid or subdural, continuous* be applied to code 62319.

CPT Code 72275
The RUC recommends that the direct inputs associated with code 72265 *Myelography, lumbosacral, radiological supervision and interpretation* be applied to code 72275.

L. Sacroiliac Joint/Paravertebral Facet Joint/Nerve Injection Procedures(Tab 16) Tracking Numbers M1-M13
Presentation: Michael Ashburn, MD American Academy of Pain Medicine; Karl Becker, MD, American Society of Anesthesiologists, Peter Dempsey, MD, American Association of Neurological Surgeons, Paul Dreyfuss, MD, American Academy of Physical Medicine and Rehabilitation; Thomas Faciszewski, MD, North American Spine Society, and Samuel Hassenbusch, American Association of Neurological Surgeons/ Congress of Neurological Surgeons.

A comprehensive, multi-issue revision to the spine injection procedures and their radiological counterparts represents code additions, deletions and revisions to certain spinal-related procedures reflecting current clinical practice across multiple specialties. The following codes do not appear in strict numeric order, in order to accurately convey intent and use.

CPT Code 27096

CPT Code 27096 *Injection procedure for sacroiliac joint arthrography and/or anesthetic/steroid* was added. This new code identifies injection of contrast for radiological study of this joint for morphological analysis and response to blockade. There previously was no specific code to identify this procedure. This procedure is widely utilized in the differential diagnosis of low back, buttock, pelvis and groin pain. Based on the survey results of 45 radiologists, the RUC supports a RVW of 1.40, which is slightly lower than the median RVU(1.50).

CPT Code 73542

CPT Code 73542 *Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation* was added. This code is the radiological counterpart to code 27096 and describes the radiological supervision and interpretation of sacroiliac joint arthrography. The procedural component of the newly-established radiological guidance and localization code 76005 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravetebral facet joint, paravertebral facet joint nerve or sacroiliac joint) including neurolytic agent destruction* is inclusive of 73542. Therefore, it would not be appropriate to report both 73542 and 76005 for SI joint arthrography. Based upon the intra-service intensity/complexity measures and the intra-service time estimates of the new code 73542 (20 minutes intra-service time & 3.5 intra-service intensity/complexity) compared to reference service codes 73525 *Radiologic examination, hip, arthography, radiological supervision and interpretation* (20 minutes, 2.1) and 72265 *Myelography, lumbosacral, radiological supervision and interpretation* (22.5 minutes, 2.7), the RUC supports the median RVU of .64 for CPT code 73542.

CPT Codes 64470 and 64472

This series of spine injection procedures has been updated to reflect and update current clinical practice. Descriptors now include spinal anatomy not previously identified; for example, in the cervical and thoracic regions of the spine. The paravertebral facet joint or facet joint nerve codes are intended to clarify the spinal anatomy, the substances injected, and the spinal level or levels involved. Certain codes (64440-64443) have been deleted to allow sequential numbering of the new paravertebral facet injection codes (64470-64476). Codes 64472 and 64476 represent add-on codes for each additional spinal level injected.

The best procedural comparison for the new CPT Code 64470 *Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level* is CPT code 64475(renumbering of Code 64442) *Injection, anesthetic agent; paravertebral*

facet joint nerve, lumbar, single level (work RVU= 1.41). The cervical risks that differ from the lumbar include, but are not limited to: potential seizures from placement of anesthetic in the vertebral artery; to nerve root damage; and quadriplegia from injection into the nerve roots or spinal cord. Based on the survey median and the relationship to CPT Code 64475, the RUC recommends an RVU of 1.85 for code 64470.

The new add-on procedure 64472 *Injection, anesthetic agent and/orsteroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* was procedurally compared to CPT Code 64476 (renumbering of 64443) *Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, each addtional level*. Based upon the survey results, the new code had a significantly higher intensity/complexity measure, 64472 (3.70) compared to the referenced procedure 64476 (3.03). The RUC supports the recommended RVU of 1.29 which represents 70% of the recommended RVU for the parent code 64470. The same ratio was used for the lumbar code set 64475/64476(1.41/ 0.98)

CPT Codes 64479, 64480, 64483 and 64484

Four new codes have been added to describe a procedurally more difficult diagnostic and therapeutic nerve root injection that requires entry into the epidural space through the nerve root foramen. Transforaminal epidural spinal injection technique is a technically different approach; and is again identified by the spinal anatomy, the substance injection, and the spinal level or levels involved. Codes 64480 and 64484 represent add-on codes for each additional spinal level injection.

Based on the survey results, the RUC supports the survey median values for the parent codes, CPT 64479 *Injection, anesthetic agent and/or steroid, transforaminal epidural, cervical or thoracic, single level* (work RVU=2.20) and CPT 64483 *Injection, anesthetic agent and/or steroid; transforaminal epidural, lumbar or sacral, single level* (work RVU=1.90). The RUC also agreed that the rationale supporting 64472 should apply to add on procedures 64480 and 64484 in that their relative values should be set at 70% of the parent codes based upon the ratio of the "anchor pair" 64475/64476- 1.41/0.98. Therefore, the RUC supports an RVU of 1.54 for code 64480 and 1.33 for code 64484.

CPT Codes 64626 and 64627

The series of neurolytic "destruction" procedures were revised (64622, 64623) and two new codes established (64626, 64627) to delineate paravertebal facet joint nerve destruction by a neurolytic agent (eg, phenol injection, radio frequency) at the cervical/thoracic, lumbar or sacral regions of the spine to reflect current clinical practice. Because the level of work performed in the cervical/thoracic levels is different, codes 64626 and 64627 were added to distinguish this work compared to the lumbar regions (64622, 64623). Codes 64623 and 64627 represent add-on codes delineating the neurolytic destruction technique performed at each single spinal level involved.

CPT Codes 64626 *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level* and 64627 *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level* were established for the cervical level to distinguish from the existing codes 64622 and 64623 for the lumbar procedures. As illustrated by the survey results, the cervical/thoracic levels are different in that the areas are smaller and the risks are higher, including risks such as seizure, paralysis, and nerve root damage. The intra-service intensity/complexity was 4.45 for the new code compared to the referenced procedure 64622. Based on the survey results, the relationship to the current lumbar code 64622, the RUC recommends a RVU of 3.28 for code 64626.

The new add-on code 64627 had significantly higher time and intensity/complexity measures compared to the referenced lumbar add-on code 64623. The RUC supports an RVU of 1.16 for code 64627 which is 34% of the recommended value for the new parent code 64626 and less than the survey median for this code. The ratio between the new codes is the same as the ratio for the lumbar code pair 64622/64623 (3.00/0.99).

CPT Code 76005

CPT code 76005 identifies the fluoroscopic "guidance" to assist in accurately localizing specific spinal anatomy for placement of a needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures. This fluoroscopy code is a stand-alone code reported in addition to the appropriate injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint) including neurolytic agent destruction. Code 76005 may be reported in conjunction with codes 62270-62273, 62280-62282, 62310-62311, 62318-62319, when required. Code 76005 should be reported in addition to 64470-64476, 64479-64484. Code 76005 is considered an inclusive component of codes 72240, 72255, 72265, 72270, 73542. The best procedural comparison for CPT code 76005 is the reference service code 76003 *Fluoroscopic localization for needle biopsy or fine needle aspiration* (Work RVU= 0.54). Based on the survey, the time estimates and the intensity/complexity measures of the new code were consistently higher than the key reference procedure. Therefore, the RUC supports the median RVU of .60 for CPT Code 76005.

Work Relative Recommendations:

The RUC supports the following work relative value units: CPT code 27096-1.40, 73542-.64, 64470-1.85, 64472-1.29, 64479-2.20, 64480-1.54, 64483-1.90, 64484-1.33, 64626-3.28, 64627-1.16, and 76005-.60.

Practice Expense Recommendations:

CPT Code 27096

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC

therefore recommends that the direct inputs associated with code 27093 *Injection procedure for hip arthrography; without anesthesia* be applied to code 27096.

CPT Code 73542

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 73525 *Radiologic examination, hip, arthrography, radiological supervision and interpretation* be applied to code 73542.

CPT Code 76005

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 76003 *Fluoroscopic localization for needle biopsy or fine needle aspiration* be applied to code 76005.

CPT Code 64470

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 64442 *Injection, anesthetic agent;paravertebral facet joint nerve, lumbar, single level* be applied to 64470.

CPT Code 64472

Since this is a new code there is currently no direct input data associated with this code. The RUC recommends 15 minutes of RN in-office, intra-service time for 64472. This time is consistent with RUC survey physician's intra-service time. Although additional supplies may be necessary for additional levels these details will be reviewed during refinement.

CPT Code 64475

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 64442 *Injection, anesthetic agent;paravertebral facet joint nerve, lumbar, single level* be applied to 64475.

CPT Code 64476

Since this is a new code there is currently no direct input data associated with this code. The RUC recommends 15 minutes of RN in-office, intra-service time for 64476. This time is consistent with RUC survey physician's intra-service time. Although additional supplies may be necessary for additional levels these details will be reviewed during refinement.

CPT Code 64479

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 64442 *Injection, anesthetic agent;paravertebral facet joint nerve, lumbar, single level* be applied to 64479.

CPT Code 64480

Since this is a new code there is currently no direct input data associated with this code. The RUC recommends 20 minutes of RN in-office, intra-service time for 64480. This time is consistent with RUC survey physician's intra-service time. Although additional supplies may be necessary for additional levels these details will be reviewed during refinement.

CPT Code 64483

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 64442 *Injection, anesthetic agent;paravertebral facet joint nerve, lumbar, single level* be applied to 64483.

CPT Code 64484

Since this is a new code there is currently no direct input data associated with this code. The RUC recommends 20 minutes of RN in-office, intra-service time for 64484. This time is consistent with RUC survey physician's intra-service time. Although additional supplies may be necessary for additional levels these details will be reviewed during refinement.

CPT Code 64626

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 64622 *Destruction by neurolytic agent;paravertebral facet joint nerve, lumbar, single level* be applied to code 64626.

CPT Code 64627

Since this is a new code there is currently no direct input data associated with this code. The RUC recommends 30 minutes of RN in-office, intra-service time for 64627. This time is consistent with RUC survey physician's intra-service time. Although additional supplies may be necessary for additional levels these details will be reviewed during refinement.

CPT Code 76005

Since this is a new code there is currently no direct input data associated with this code. The specialties chose to crosswalk this code to an existing code which has direct inputs that the specialty feels is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 76003 *Fluoroscopic localization for needle biopsy or fine needle aspiration* be applied to code 76005.

M. Percutaneous Lysis of Epidural Adhesions (Tab 17) Tracking Number S1 Presentation:Doctors Samuel Hassenbusch, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons & Peter Dempsey, American Association of Neurological Surgeons

A new code was created (CPT 62263) was created to describe *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wound catheter) including radiologic localization (includes contrast when administered).* The new code describes percutaneous catheter-based treatment to reduce or eliminate inflammation and scaring in and around nerve roots or spinal nerves. After the catheter is placed, under fluoroscopic guidance, a series of injections or infusions are given over a span of one to four days, with repeat epidurograms to verify correct catheter placement and evaluate the opening of constricted scar areas around the target nerves/nerve roots.

The procedure is performed about 1,000-2,000 times annually at multiple centers. This is a very selected technique for a specific subset of patients with chronic low back pain with radiculpopthy. The services performed are currently reported under 64999 *Unlisted procedure, nervous system.*

Physicians developed a building block approach when proposing a work relative value unit. The building block approach estimates the typical patient as having a 2.5 injections /infusions over a two-three day hospital stay. Four components were included in this analysis:

Component 1: Catheter Placement and Injection of Anesthetic and Contrast: CPT 62279 *Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, lumbar or caudal, continuous* (work RVU = 1.58) most accurately covers this phase of the service, since it includes insertion of a catheter into the lumbar epidural space for injection of a diagnostic or therapeutic substance. Twice the total work of CPT 62279 is approximately equal to the first part of 62263 in that it covers catheter insertion into a scarred epidural space, injection of contrast and analgesic, and steering the catheter tip into the position to deliver a neurolytic substance aimed at the adhesions. This equates to 3.16 rvus (2 x 1.58 rvus).

Component 2: Injections/Infusions: CPT 62282 *Injection of neurolytic substance (eg alcohol, phenol, iced saline solutions); epidural, lumbar or caudal* (work rvu= 2.33) is used as a reference for this component since it covers the injection of neurolytic material into the lumbar epidural space. CPT 62282 has a rvu of 2.33 and a global period of 10 days. The RUC estimated that the "injection" portion of 62282 is approximately 1/3 of the total work or .77 rvus. It was also estimated that that the typical patient will receive between two to three injections. This equates to 1.94 rvus (2.33 rvus x .33% x 2.5 injections).

Component 3: Fluoroscopic Guidance: New code 7600 (M13) is used as a reference code for this component which is included as part of new code 62263 and not separately billable. It is estimated that fluoroscopic guidance will be required for the initial catheter steering and placement, and once more during one of the repeat injections to further examine catheter position. This equates to 1.20 rvu's(2 x .60 rvus).

Component 4: Evaluation and Management: The survey results indicate, and RUC members agreed, that there would be two Level 2 post discharge office visits. This equates to .90 rvu's (2 x .45 rvus).

These components equal 7.20 rvus (3.16 + 1.94+ 1.20 + .90). The RUC agreed that this value was a reasonable recommendation for this new code, which has bundled procedures and work from several codes into one. Based on this analysis, the RUC recommends acceptance of 7.20 as the work relative value unit for newly created CPT code 62263.

Work Relative Value Recommendations: The RUC recommends acceptance of 7.20 for CPT code 62263.

Practice Expense Recommendations: The RUC is not making any practice expense recommendations for this code. The RUC agreed to table the practice expense recommendations since it was not able to fully evaluate the specialties' recommended crosswalk for this code.

N. Deep Brain Stimulation(Tab 18) Tracking Numbers AA1-AA6
Presentation:Doctors Samuel Hassenbusch, MD, American Association of Neurological Surgeons/Congress of Neurological Surgeons & Peter Dempsey, American Association of Neurological Surgeons

A series of new codes has been established to replace existing deep brain stimulation codes and to reflect new technology and clinical practice advances. These codes will also eliminate individual current codes that emphasize minor differences in the type of skull opening used to place the electrode tray.

CPT Code 61862

CPT code 61862 *Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)* was established to better model the clinical practice for deep brain stimulation. In considering a relative value for this new code, the RUC took into account the following: 1) Elements of new technology; 2) Increased work (time and intensity); 3) Building block comparisons; and 4) Survey responses. It was agreed that this procedure represents new technology in its hardware and target sites for stimulation, and disorders to be treated. The RUC also agreed that this new procedure involves more time than in CPT codes 61855 *Twist drill or burr hole(s) for implantation of neurostimulator electrodes; subcortical* (work RVU = 13.39) and 61865 *Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral; subcortical* (work RVU = 22.97). CPT code 61855 will now be deleted and crosswalked to the new code. This is due to the addition of stereotactic localization of the target for stimulation and the need to perform intraoperative stimulation as a test of the safety and effectiveness of the electrode placement.

Therefore, the RUC supports the specialty society's work recommendation of 27.34. This value was determined using the building block approach: 1) The stereotactic work is similar to CPT 61795 *Stereotactic computer assisted volumetric intracranial procedure* (work RVU = 4.04); 2) The portion of the work done in the operating room includes those services in the deleted codes based on an estimated frequency of 4:1 (eg, 80% 61855 and 20% 61865)= 15.30; and lastly, 3) The final intraoperative element to be included is the testing and repositioning of the electrode array. Using the survey median intraoperative time of 320 minutes and subtracting 120 minutes (for stereotactic work) and 60 minutes (for opening the skull, placing the electrode, and closing after testing, = 140 minutes. This number is equivalent to two hours of critical care management (CPT 99291/99292) = 8.00. The sum of these estimates equals the recommended value of 27.34.

CPT Codes 61885 & 61886

The revision to CPT code 61885 *Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; <u>wit</u>h connection to a single electrode tray* and the creation of CPT code 61886 *(with connection to two or more electrode arrays)* were adopted to reflect changes in clinical practices. Although this procedure is done primarily as a one-stage procedure, the RUC was concerned that there would be double counting of post-service and discharge day work. Therefore, the RUC agreed to subtract the following from 61885's median RVU: (Four office visits at 0.67 RVUs & .32 for the Discharge Day Management) for a recommended RVU of 8.00 for revised CPT Code 61885.

The RUC used the same methodology to calculate a work RVU for CPT Code 61886 *Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays*. However, the RUC unanimously supported using an RVU of 11.00 as a starting point as it more accurately reflects the work of 61886 rather than the median RVU of 15.00. The RUC supports a work RVU of 8.00 for CPT Code 61886.

CPT Code 64573

The revised CPT Code 64573 *Incision for implantation of neurostimulator electrodes; cranial nerve* is an outdated code that is no longer in use. For this reason, the code became part of the review and survey for the deep brain stimulation codes. The new procedure now involves an open operation to place a spiral electrode on the vagal nerve and also include a long area of dissection of the carotid artery. The RUC agreed that the work involved in this service was comparable to the work of CPT code 35800 *Exploration for postoperative hemorrhage, thrombosis or infection; neck* (work RVU= 7.02). However, 64573 had additional time, complexity and risk of side effects. The RUC supports the specialty society's recommendation of 7.50 for CPT code 64573.

Work Relative Value Recommendations: The RUC supports acceptance of 27.34 for CPT code 61862, 8.0 for CPT code 61885, 8.0 for CPT code 61886 and 7.5 for CPT code 64573.

Practice Expense Recommendation:The RUC is not making any practice expense recommendations for these codes. The RUC agreed to table the practice expense recommendations since it was not able to fully evaluate the specialties' recommended crosswalk for these codes.

O. Resection/ Reconstruction of Diaphragm (Tab 19) Tracking Numbers Q1-Q2 Presentation: Doctor Sidney Levitsky, Society of Thoracic Suregons

Two new CPT codes were created that relate to the resection and reconstruction of the diaphragm. CPT code 39560 *Resection, diaphragm; with simple repair (eg, primary suture*) and 39561 *Resection, diaphragm; with complex repair (eg, prosthetic material, local muscle flap)* were approved for use in CPT 2000. These services are performed in conjunction with treating primary benign and malignant lesions of the diaphragm; lung cancer involving the diaphragm; and hepatic or gastric neoplasms invading the diaphragm. These procedures have been widely used and accepted for over twenty years.

The codes describe the intentional incision and resection of the diaphragm. Previously, there were no codes available to report these services. They also describe the reconstructive procedure which currently is inaccurately described by CPT 39501 *Repair, laceration of diaphragm, any approach* (work RVU = 13.19) and 39540 *Repair, diaphragmatic hernia(other than neonatal), traumatic, acute* (work RVU=13.32). Neither of these two current codes includes utilization of graft material, which is often required. The new codes accurately describe the services and differentiate them from the diaphragmatic repairs and imbrication, which are adequately described in CPT.

With respect to proposed work relative value units for code 39560, RUC participants reviewed survey and time data and considered the survey median of 14.00. However, physicians commented and RUC members decided, that compared to the complex repair with

prosthetic material and muscle flap (as identified in CPT 39561), the 25th percentile RVW was more appropriate.

The RUC therefore recommends acceptance of 12.00 as a work relative value unit for code 39560.

With regard to code 39561, RUC members evaluated the physician work for reference codes 43331 *Esophagomyotomy (Heller type); thoracic approach* (work RVU= 16.23) and 32220 *Decortication, pulmonary(separate procedure); total* (work RVU=19.27). In addition they considered the survey median of 17.50. It was the consensus of the RUC that the survey median accurately reflected the physician work. The RUC therefore recommends acceptance of 17.50 as a final work relative value unit for CPT 39561.

Work Relative Value Recommendations: The RUC supports a work relative value of 12.00 for CPT code 39560 and 17.50 for CPT 39561.

Practice Expense Recommendations: No practice information was submitted for these codes. As such, the RUC does not have any formal practice expense recommendations at this time.

P. Transmyocardial Revascularization (Tab 20) Tracking Numbers R1
Presentation: Doctor Sidney Levitsky, Society of Thoracic Surgeons

A new CPT Code 33140, *Transmyocardial laser revascularization, by thoracotomy (separate procedure)* has been established to describe a new type of myocardial revascularization procedure that is becoming recognized by the cardiothoracic surgical community as a useful alternative or adjunct to coronary artery bypass grafting. In absence of a specific code, this procedure is being reported as one of the following: CPT 33999 *Unlisted procedure, cardiac surgery* (work RVU= Carrier Priced); CPT 33020 *Pericardiotomy for removal of clot or foreign body (primary procedure)* (work RVU=12.61); and CPT 32100 *Thoracotomy, major; with exploration and biopsy* (work RVU=11.84).

These codes are inadequate to describe the new type of revascularization process as they are either too vague, describe only a portion of the service, or do not clearly describe the work. The work involved in 33140 is similar to CPT 33512 *Coronary artery bypass, vein only; three coronary venous grafts* (work RVU= 29.67). Because the intra-service time of the reference service was 32% greater than 33140, the committee supports a work RVU of 20.00. This value is also the 25th percentile of the survey data.

Work Relative Value Recommendation: The RUC recommends acceptance of 20.00 for CPT code 33140.

<u>Practice Expense Recommendation:</u>The specialty suggested a crosswalk of practice expense during their presentation to the RUC. However, the RUC agreed not to review any practice expense crosswalks that were not submitted in writing prior to the meeting. Therefore, the RUC is not making a practice recommendation for this code.

Q. Aortic Value Replacment (Tab 21) Tracking Numbers V1-V2
Presentation: Doctor Sidney Levitsky, Society of Thoracic Surgeons

A new CPT code, 33410, was adopted to report *Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve.* This type of procedure is performed on patients with aortic valve stenosis or aortic valve insufficiency.

Stentless aortic valves represent a new generation of aortic value prosthesis. Due to their design, they lack the rigid stent and sewing ring of older valves. Their flexibility and three-dimensional character requires a more complex insertion technique, involving suturing at both the inlet and outlet portions of the valve. The new code reflects new technology in that the stentless valve and the sizing and insertion techniques are new.

The procedures are currently being reported under CPT 33405 (with a-22 modifier) and CPT 33406. CPT 33405 describes *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft* (work RVU=30.61). CPT code 33405 reflects the insertion of aortic valve prosthesis with a sewing cuff, thus involving only a single interrupted or continuous suture line. Insertion of a stentless aortic valve involves not only a lower annular suture line, but also an upper outlet suture line. The Medicare work values assigned to CPT 33405 are not adequate, thus necessitating the use of Modifier –22.

Similarly, CPT 33406 *Replacement, aortic valve, with cardiopulmonary bypass; with homograft valve (freehand*) (work RVU= 32.30) is a more difficult type of insertion involving a freehand style using a homograft valve. Physicians commented and RUC members agreed that the total work, intensity, skill, and time are similar to the stentless implantations, but that the code descriptor does not fit the stentless valve insertion.

In developing a final work relative value recommendation, the RUC considered the comparability of CPT 33406, but also agreed that the physician work involved in the new code CPT (33410) was more difficult of a procedure to perform. As such, it was the consensus of the RUC that a rvu of 32.46 represented a fair and accurate value for CPT 33410.

<u>Work Relative Value Recommendations:</u> The RUC supports a work relative value of 32.46 for CPT code 33410.

<u>Practice Expense Recommendations</u>: No practice information was submitted for these codes. As such, the RUC does not have any formal practice expense recommendations at this time.

R. Lower Extremity Arterial Bypass (Tab 22) Tracking Numbers W1-W2
Presentation: Doctors Gary Seabrook, & Bob Zwolak, Society for Vascular Surgery

New CPT codes were added to describe work performed on established lower extremity bypass graft in order to prevent thrombosis of the graft and subsequent limb loss. The intraservice work involved with CPT Code 35879 *Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty* equals that of two comparison codes, CPT 35876 *Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft* (work RVU= 17.00) and CPT 35256 *Repair blood vessel with vein graft; lower extremity* (work RVU=11.38). The pre-service time is higher than the comparison code while the post-since time is less than in 35876 but more than in 35256. The intensity factors for the new code are very similar to those of 35876, but generally greater than those of 35256. Based upon the survey data, the RUC supports the specialty society's recommended RVU of 16.00 for CPT code 35879, which represents the median RVU.

The RUC recommends that CPT Code 35881 *Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition* be assigned a work value of 18.00, based on a survey of 42 vascular surgeons. The recommendation of 18.00 for 35881 also represents the median RVU.

Work Relative Value Recommendations: The RUC supports a work relative value of 16.00 for CPT code 35879 and 18.00 for CPT Code 18.00.

Practice Expense Recommendations: Since these are new codes, there currently are no direct inputs assigned to these codes. The specialty chose to crosswalk these codes to an existing code which is similar in not only in the physician work involved but also has inputs that the specialty believes is representative of the expenses associated with the new codes. The RUC therefore recommends that the direct inputs associated with code 35301 *Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision* also apply to the new codes 35879 and 35881.

S. Arteriovenous Anastomosis (Basilic Vein Transposition) Tab 23 Tracking Y 1-Y2
Presentation: Doctors Gary Seabrook, & Bob Zwolak, Society for Vascular Surgery

A new code was adopted for inception into CPT 2000: Code 36819 *Arteriovenous anastomosis, open; by basilic vein transposition*. Creation of an arteriovenous fistula using transposition of the basilic vein above the elbow is a procedure that has been used intermittently for many years. The frequency of this operation is increasing as the dialysis population grows and as clinicians realize the improved utility of all autogenous hemodialysis access. Basilic vein transposition entails much more work than placement of non-autogenous upper arm graft since it requires complete dissection of the entire basilic vein from the antecubital crease up to the axilla.

In describing the procedure, the RUC compared the new code to two existing CPT codes: 36821 and 36825. CPT code 36821 *Arteriovenous anastomosis, direct, any site (eg, Cimino*

type) (separate procedure) (work RVU= 8.93) involves direct anastomosis of a vein to an artery, usually at the wrist, with only a moderate amount of arterial and venous dissection. The Cimino fistula does not involve extensive dissection, as does the basilic vein transposition. The basilic vein is much deeper in the soft tissue and almost always has overlying nerves that must be preserved. The basilic vein transposition procedures require a complete, longitudinal vein dissection for the entire length of the upper arm, creation of a tunnel, and relocation of the vein into the new, more superficial location. None of these maneuvers are part of CPT 36821.

In its review of the new procedure, the RUC also considered CPT code 36825 *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft* (work RVU= 9.84). CPT code 36825 defines a different service than basilic vein transposition. Code 36825 involves placement of a "graft," and there is no such graft in basilic vein transposition.

Also with respect to physician work, the RUC considered the comparison code of 36830 *Creation of arteriovenous fistula by other than direct arteriovenous anastomois (separate procedure); nonautogenous graft* (work RVU = 12.00). The new service requires 30 minutes more operative time and a few minutes more pre and post time than the comparison code 36830, which is the most commonly performed dialysis access operation. All mental effort, judgement, technical skill and psychological stress parameters are greater in the new code because the basilic vein must be handled with extreme care to avoid injury, while the synthetic conduit in code 36830 is nearly indestructible.

In appraising potential work relative values, the RUC considered the survey median of 14.00. Also, given the increase in time and other related factors, the RUC agreed that the relative value units for code 36819 should be approximately 2 rvu's greater than that of CPT 36830. The RUC therefore recommends a work RVU of 14.00 for CPT code 36819.

Work Relative Value Recommendation: The RUC supports a work relative value recommendation of 14.00 for CPT code 36819.

Practice Expense Recommendations: Since this is a new code there is currently no direct input data associated with this code. The specialty chose to crosswalk this code to an existing code which is similar not only in the physician work involved but also has direct inputs that the specialty believes is representative of the expenses associated with the new code. The RUC therefore recommends that the direct inputs associated with code 36830 *Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft* also apply to code 36819.

T. Vascular Access Device Procedures: Tab 24 Tracking Number T1
Presentation: Doctors David Regan, American Society of Clinical Oncology

CPT Code 36550 *Declotting by thrombolytic agent of implanted reservoir vascular access device or catheter* was created to describe ongoing, intermittent and/or maintenance therapy to cancer patients through a reservoir vascular access device. Survey information regarding this code was presented and committee members noted inconsistencies with the survey instrument,data and vignette. Committee members were not able to reach a consensus regarding an appropriate work relative value , and unanimously referred the issue back to the specialty society for reexamination. It is expected that specialty society will resurvey, and will present revised information to the RUC for consideration at a later date.

Work Relative Value Recommendation: Based on the recent activity, the RUC is unable to make a final recommendation regarding physician work at this time.

Practice Expense Recommendation: Based on the recent activity, the RUC is unable to make a final recommendation regarding practice expense at this time.

U. Acute Thrombosis Imaging: Tab 25 Tracking Number BB1
Presentation: Doctor Kenneth McCusick, Society of Nuclear Medicine

A new code was developed CPT 78456, to report *Acute venous thrombosis imaging, peptide*. The new procedure uses a systematically injected radiolabeled peptide that binds to activated platelets for imaging acute thrombosis. Prior to the creation of this code, there were no codes to report this procedure. It was recommended that physicians report the services under CPT 78499 *Unlisted cardiovascular procedure, diagnostic nuclear medicine.*

The services reported under CPT 78456 were recently introduced following FDA approval of the radiopharmaceutical this year. The procedure can be performed in any inpatient or outpatient nuclear medicine facility with a standard scintillation imaging camera. The new procedure is imaging of an acute thrombosis. In this way, it is somewhat analogous to CPT code 78455 *Venous thrombosis study (eg radioactive fibrinogen)* (work RVU= .73). Code 78455 represents another method for finding a venous clot with an agent that binds to an acute clot. The difference between the two procedures is that the new code uses a radioactive contrast agent that does not need to be monitored over several days time after injection for new clot formation, and that it is an imaging and not a non-imaging study.

When considering potential work relative units, the RUC discussed values for similar reference codes, such as CPT 78278 *Acute gastrointestinal blood loss imaging* (work RVU=.99) and CPT 78585 *Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath* (work RVU=1.09). They also considered physician survey results, and agreed that the survey median for physician work was an accurate value for the new procedure.

Work Relative Value Recommendation:The RUC therefore recommends a rvu of 1.00 for the physician work component of the new CPT Code 78456.

Practice Expense Recommendations:Since this is a new code there currently are no direct inputs associated with this code. The specialty developed the direct input

recommendations using a small consensus panel that examined CPEP data for similar codes. The RUC accepted the direct input recommedations but deleted three supplies; the saline, i.v. infusion set, and the angiocatheter. See the attached direct input summary of recommendation form.

V. Photodynamic Therapy: Tab 26 Tracking Number H1

In August 1998, the CPT Editorial Panel approved the addition of two new codes to report photodynamic therapy: CPT 96570 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissuevia activation of photosensitive drug(s); first 30 minutes* and CPT 96571 *Photodynamic therapy by endoscopic application of ight to ablate abnormal tissue via activiation of photosensitve drug(s); each additional 15 minute*s. Throughout the remaining RUC and CPT cycles for CPT 2000, only one specialty indicated an interest in surveying the new codes for work and practice expense values. At a later date, the society expressed concern regarding the physician sample size, and stated that their data would potentially be invalid and not statistically significant due to the low response rate. Their request to survey was substantially withdrawn. You may refer to the correspondence for information regarding these new codes.

Work Relative Value Recommendations: Based on the absence of formal survey data, the RUC unable to make a final recommendation regarding physician work at this time.

Practice Expense Recommendations: Based on the absence of formal survey data, the RUC is unable to make a final recommendation regarding practice expense at this time.

W. Low Intensity Bone Ultrasound: Tab 27: Tracking Number F1

Presentation:

The CPT Editorial Panel at its August 1998 meeting approved CPT code 20979 *Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)*. Throughout the remaining RUC and CPT cycles for CPT 2000, no specialty society indicated an interest in surveying the new code for work or practice expense values. At its May RUC 1999 meeting, specialty societies did discuss and comment on potential values despite the absence of formal survey data. Many physicians agreed that the work described in CPT code 20979 was very similar to the procedure reported under CPT 20974 *Electrical stimulation to aid bone healing; noninvasive (nonoperative*) (work RVU= .62, Non-Facility PE RVU=.33). Other RUC members indicated that the code was very similar to CPT 76880 *Echography, extremity, non-vascular, B-Scan and/or real time with image documentation* (work RVU = .59, Non-Facility PE RVU = 1.64).

Work Relative Value Recommendation:The RUC recommends that HCFA consider this information when formulating a final work relative value unit. However, based on the absence of formal survey data, the RUC is unable to make a final recommendation regarding physician work at this time.

Practice Expense Recommendations:The RUC's discussion of practice expense for this particular issue was very limited. As such, based on the absence of formal survey data, the RUC is unable to make a final recommendation regarding practice expense at **this time.**

X. Extracorporaeal Immunoadsorption: Tab 28: Tracking Number X1
Presentation:

The CPT Editorial Panel approved CPT Code 36521 *Therapeutic apheresis; with extracorporeal affinity adsorption and plasma reinfusion.* The American College of Rheumatology elected not to survey the new code for work or practice expense values due to concerns regarding the ability to obtain an adequate sample size. At its May 1999 RUC meeting, specialty societies did discuss and comment on potential values despite the absence of formal survey data. Many physicians agreed that the work described in CPT 36521 was very similar to the procedure reported under CPT Code 36520 *Therapeutic apheresis; (plasma and/or cell exchange)* (work RVU = 1.74).

The specialty society chose to withdraw this issue from the May 1999 RUC agenda. In addition, it was noted that the code will be referred to the CPT Editorial Panel for further revision. HCFA may consider this information when formulating a final work relative value unit. However, based on the absence of a formal survey data, the RUC is unable to make a final recommendation regarding physician work at this time.

Work Relative Value Recommendation: The RUC does not have a work relative value recommendation for this new CPT Code 36521 due to the absence of survey data.

Practice Expense Recommendations:The RUC's discussion was very limited but the specialty society stated that practice expense value for the new code should be higher due to the use of the column equipment. However, based on the absence of formal survey data, the RUC is unable to make a final recommendation regarding practice expense at this time.

XII. Practice Expense Advisory Committee Report

Doctor Ogrod presented the results of the PEAC meeting that was held on April 15-17, 1999. Doctor Ogrod explained that the PEAC was forwarding for RUC approval the direct inputs for a total of 68 codes. These are codes primarily selected by specialty societies that intended to make adjustments in the CPEP direct input data so HCFA could make changes in the 2000 fee schedule. While the PEAC began its April deliberations without formally established guidelines, the PEAC agreed in February that such a meeting was necessary to afford specialties an opportunity to correct flawed CPEP data. The PEAC will continue to develop procedures for reviewing direct input data, and has already identified a number of issues that need further review. PEAC members raised these issues during the course of the April PEAC meeting. To begin the process of resolving these issues, the PEAC will form an ad-hoc taskforce to examine these issues in greater detail this summer. Then, when the PEAC meets in September, the PEAC members will use that meeting to develop a formal methodology for reviewing CPEP data.

RUC members were concerned that the PEAC report did not contain a detailed explanation of why certain inputs were not accepted by the PEAC. Doctor Ogrod explained that in almost

every instance when the PEAC did not accept the direct inputs for a code it was because the clinical staff time appeared excessive. Often the presenters were unable to adequately justify to the PEAC the increased clinical staff time, or were unable to justify that all of the staff activities were indeed clinical activities. While the criteria that the PEAC members applied to data may have changed throughout the meeting, it was mostly a result of the PEAC members becoming accustomed to reviewing and discussing the direct input data. Several RUC members stated that it was their understanding that the justifications required by PEAC members may have become more stringent as the meeting progressed.

Doctor Ogrod agreed with comments made by several RUC members that the goal of the PEAC should be to review the direct input data and that a framework that is fair across all specialties should be established. Although, changes in CPEP data will impact multiple specialties, assessing impacts should not be the focus of the PEAC.

Several RUC members expressed concerns about the fairness of the PEAC's analysis since some PEAC members stated that changes should not be made to CPEP data until the impact of proposed changes were actually known. Given the inability of the PEAC to correct data errors such as the overstated clinical staff time associated with code 99213, several RUC members questioned the validity of the entire report and suggested that forwarding the report to HCFA at this time is premature. Other RUC members echoed these concerns and stated that PEAC recommendations should not be sent to HCFA until the PEAC has developed a standard methodology and ground rules for reviewing CPEP data.

Recognizing concerns with the direct inputs which the PEAC approved, the RUC passed the following motion:

- The RUC acknowledges the efforts of the PEAC to arrive at practice expense inputs, and that they have been identified in their deliberations numerous problems inherent in such a process; therefore the RUC accepts the report as informational but, in the absence of a formal defined methodology, the RUC will not forward the PEAC report to HCFA at this time.

The PEAC report was approved and is attached to these minutes.

XIII. Practice Expense Subcommittee Report

Doctor Lichtenfeld presented the results of the Practice Expense Subcommittee meeting. The subcommittee is continuing to examine the time data that HCFA used to calculate the practice expense cost pools. It is important that HCFA use the most accurate time data, and the subcommittee will discuss this issue further with HCFA staff to determine why the adjustments were made. Additionally, specialty society staff are in the process of reviewing survey data for new and revised codes which the RUC has approved. Since the RUC will forward to HCFA all time data associated with codes approved by the RUC, the RUC wanted to make sure that the RUC time data did not contain any data input errors. Since the RUC time data contains instances where multiple specialties presented time data for a single code, the RUC agreed to weight the time data according the Medicare frequency. In cases where frequency data is not available for a given code and specialty, the specialty will provide the

AMA staff with the appropriate weighting for their time data. A listing of these codes are contained in tab 31 of the RUC agenda book, and specialties are directed to make a determination of the percentage of code utilization so a weighted average time can be forwarded to HCFA.

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

XIV. Research Subcommittee Report

Doctor Florin summarized the Research subcommittee's discussions concerning the definitions of clinical staff time periods that are included in the RUC practice expense survey. The research subcommittee had originally intended to maintain the same definitions between the work and practice expense surveys for consistency, but is now considering changing the time periods for clinical staff time. As a result of the research subcommittee's discussion of clinical staff time periods, the RUC passed the following motion:

The RUC Practice expense survey shall use the following time periods for collecting clinical staff time data:

- **time from the decision to have a procedure (surgery) until admission to hospital;**
- **time from hospital admission to the beginning of the intra-service period;**
- **time of the intra-service period;**
- **time from the completion of the procedure until hospital discharge; and**
- **time from discharge until expiration of the global period.**

The practice expense survey is still undergoing refinement since some RUC members have requested additional ground rules to be incorporated in the survey. Dr. Florin therefore asked RUC members to provide him with specific suggestions for inclusion in the RUC practice expense survey.

Several RUC members expressed concern over the recommendation that specialties can collect practice expense data either through the draft RUC practice expense survey or through a consensus panel. There was discussion regarding the validity of the use of consensus panels with RUC members both supporting and opposing such a method for collecting practice expense data. Some felt that since the RUC requires a survey for developing work recommendations the same standard should apply to practice expense. Others thought that a survey is not needed for practice expense, especially for identifying the supplies and equipment inputs. Finally, the RUC discussed HCFA's overall methodology which seek to identify practice expense for a typical practice. Given the wide variety of practice settings a

RUC member questioned whether forcing all practices to be reimbursed on a "typical" mode of practice is valid.

Doctor Florin presented his analysis of the paired comparison methodology for determining the work RVUs for a set of injection codes. Doctor Florin discussed some of the limitations of the methodology and agreed to report back to the RUC with more specifics on implementing such a methodology. It was discussed that HCFA has received the report from its contractor on the five year review and that use of the paired comparison methodology is listed as one option for consideration. HCFA officials stated that they hope to release the report sometime this summer.

Doctor Lichtenfeld requested that the minutes note that he neither participated or voted on the paired comparison methodology discussion since he is an advisor to the HCFA contractor which is developing recommendations for the five year review.

The Research Subcommittee Report was approved and is attached to these minutes.

XV. Administrative Subcommittee Report

ADD

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

XVI. Other Issues

Doctor Gage provided the RUC with an overview of the Global Surgical Workgroup's recent activities. The workgroup consisting of Doctors John Gage (Chair), William Gee, Clay Molstad, Bruce Sigsbee, and William Winters have yet to formalize a recommendation on how to handle the current inconsistency amongst global surgical periods for certain surgical procedures as this is a very complex problem with many implications. At this time, Doctor Gage opined that the RUC should consider referring this issue to Doctor Gee that sits on a CPT-5 workgroup for further discussion. The Global Surgical Workgroup agreed that in the interim, the workgroup will look at issues and any recommendations coming out of CPT-5 and have a more concrete analysis to present to the RUC in September. Based upon the workgroup's discussion, the RUC passed the following motion:

A recommendation should come from the RUC that Global Periods should reflect a fair policy that deals with all physicians in an even handed manner, and specialty society RVS committees should review the global periods assigned to their services and determine if there are any inconsistencies that should be brought to the attention of the RUC and HCFA.

Doctor Rich clarified that the PEAC report was accepted by a voice vote, but not a writtenbllwithout a formal vote by the RUC. Doctor Rich requested that the RUC reconsider Tab 1 a supply edit, known as the 130 million dollar supply mistake in HCFA's spreadsheet

for the intermediate eye code 99212. Comparing the supply inputs for three only eye codes which are the same compared to CPT 99212, it appears this code was entered incorrectly. The PEAC approved that the data edit be corrected in the spreadsheet as there is now a rank order anomaly where an intermediate established eye code is greater than new patient code which is greater than the new patient comprehensive code. Doctor Rich requested that the RUC consider this issue so it may be submitted to HCFA by July. The RUC approved the following motion:

The supply edit for CPT Code 92012, an intermediate eye code will be sent as a separate issue to HCFA.

Doctor Sigsbee raised his concern about the lack of standardized definitions used in the current survey instrument for the collection of practice expense definitions. Doctor Sigsbee proposed and the RUC approved the following motion:

The Research Subcommittee should be responsible for pulling CPEP definitions in the next two months to forward to the RUC for their review so the definitions can be incorporated into the survey instrument and forwarded to specialty societies for their comments before the next meeting.

Lastly, the RUC expressed appreciation for Doctor Hanley's efforts as the acting chair during this challenging meeting.

The meeting adjourned at 11:10 a.m.