AMA/Specialty RVS Update Committee
Meeting Minutes
September 29 – October 2, 2005

I. Welcome and Call to Order

Doctor William Rich called the meeting to order on Thursday, September 29, 2005, at 1:15 pm. The following RUC Members were in attendance:

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

*Alternate

II. Chair's Report

Doctor Rich made the following announcements:

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

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

- Doctor Rich welcomed new RUC members:
  - David Regan, MD, American Society of Clinical Oncology
  - James B. Regan, MD, American Urological Association
  - Charles Mick, MD, North American Spine Society
  - Thomas A. Felger, MD, American Academy of Family Physicians

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

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

- Doctor Rich announced the members of the Facilitation Committees:

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

- Richard W. Whitten, MD

Facilitation Committee #2

- John E. Mayer, MD (Chair)
- Mary Foto, OTR
- John O. Gage, MD
- Robert Kossmann, MD
- Charles Mick, MD
- David Regan, MD
- Daniel Mark Siegel, MD
- J. Baldwin Smith, MD
- Richard H. Tuck, MD
- Trexler Topping, MD
- Arthur Traugott, MD

Facilitation Committee #3

- J. Leonard Lichtenfeld, MD (Chair)
- James Blankenship, MD
- James P. Borgstede, MD
- John Derr, MD
- Emily H. Hill, PA-C
- David Hitzeman, DO
- Barbara Levy, MD
- Terry M. Mills, MD
- Willard Moran, MD
- Gregory Przybylski, MD
- Susan Strate, MD

- The following individuals were observers at the September 2005 meeting:

FirstName	LastName	Society
Deb	Abel	American Academy of Audiology
Gregory	Barkley, MD	American Academy of Neurology
Leon	Benson, MD	American Society for Surgery of the Hand
David	Beyer, MD	American Society for Therapeutic Radiology and Oncology
Michael	Bigby, MD	American Academy of Dermatology
Stephen	Black-Schaffer, MD	College of American Pathologists
Andrea	Boon, MD	American Association of Electrodiagnostic Medicine
Karen	Borman	American College of Surgeons
James	Boxall	American College of Cardiology
Randy	Brooks	American Optometric Association
Michael	Chaglasian, OD	American Optometric Association
Jodi	Chappell	American Academy of Audiology
Leslie	Cohen, MS	American College of Medical Genetics

FirstName	LastName	Society
John	Coleman, MD	American Academy of Otolaryngology - Head and Neck Surgery
Scott	Collins, MD	American Academy of Dermatology
Jeffery	Dann, MD	American Urological Association
Verdi	DiSesa, MD	Society of Thoracic Surgeons
Mary	Essling	American Society of Plastic Surgeons
Mary Ellen	Fletcher	American College of Emergency Physicians
L. Neal	Freeman, MD	American Academy of Ophthalmology
Kim	French	American College of Chest Physicians
Denise	Garris	American College of Cardiology
John	Goodson, MD	American College of Physicians
Robert	Guyton, MD	Society of Thoracic Surgeons
Katie	Hanson	American Association of Electrodiagnostic Medicine
C. Anderson	Hedberg, MD	American College of Physicians
Jenna	Kappel	American Society for Therapeutic Radiology and Oncology
Tripti	Kataria	American Society of Anesthesiologists
Wayne	Koch, MD	American Academy of Otolaryngology - Head and Neck Surgery
Gayle	Lee	American Physical Therapy Association
James	Levett, MD	Society of Thoracic Surgeons
Michael	Levy, MD	American Society for Gastrointestinal Endoscopy
Jennifer	Markkanen	American Academy of Sleep Medicine
Ted	Martin, MD	American College of Cardiology
Nancey	McCann	American Society of Cataract and Refractive Surgery
Marilyn	McMillen	American Academy of Family Physicians
Najeeb	Mohideen, MD	American Society for Therapeutic Radiology and Oncology
Janemarie	Mulvey	College of American Pathologists
Alan	Perlman, MD	American College of Cardiology
Michael	Picard, MD	American College of Cardiology
John	Ridge, MD	American Academy of Otolaryngology - Head and Neck Surgery
Chad	Rubin, MD	American College of Surgeons
Paul	Rudolf, MD	American College of Physicians
James	Scroggs	American College of Obstetricians and Gynecologists
Albert	Strunk, MD	American College of Obstetricians and Gynecologists
Kim	Thomsen, MA	American Dietetic Association
William	Van Decker, MD	American College of Cardiology
Paul E.	Wallner, DO	American Society for Therapeutic Radiology and Oncology
Franklin	West	Society for Vascular Surgery
Joanne	Willer	North American Spine Society
Marc	Williams, MD	American College of Medical Genetics
George	Williams, MD	American Academy of Ophthalmology
W. Patrick	Zeller, MD	American Association of Clinical Endocrinologists

- Doctor Rich thanked John E. Mayer, Jr., MD for all his hard work on the RUC

- Doctor Rich thanked the following Five-Year Review workgroup chairs and presented them with a gift for all their hard work:
    - Barbara Levy, MD
    - Richard H. Tuck, MD
    - Michael D. Bishop, MD
    - Robert M. Zwolak, MD
    - Norman A. Cohen, MD
    - James P. Borgstede, MD
    - J. Baldwin Smith, III, MD
    - Bernard Pfeifer, MD

- Doctor Rich thanked Meghan Gerety, MD for serving as the Chair of the Five-Year Review Workgroup and presented her with a gift.

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

- Doctor Rich welcomed the following Medicare Payment Advisory Commission (MedPAC) staff:
    - Kevin Hayes
    - Dana Kelley
    - Carol Carter

- Doctor Rich reiterated that we are not here representing specialties; we are representing an attempt to have an equitable distribution of fair allocation of the work values in this Five-Year Review.

III. Directors Report

Sherry Smith announced:

- The calendar of meeting dates and locations
- The new subcommittee and workgroup members will take effect immediately following this meeting
- To date there are about a dozen rank order anomalies identified by the Five-Year Review Workgroup that need to be addressed in February, which are dependent on the RUC's final actions at this meeting, including the following codes: 17004, 33506, 33660, 33670, 33770, 33780, 44141, 44144, 44145, 44146 and 44177.

IV. Approval of Minutes for the April 27-May 1, 2005, RUC meeting:

The RUC reviewed the minutes and accepted them as presented.

V. CPT Editorial Panel Update

Doctor Peter Hollmann invited the RUC to the Annual CPT Editorial Meeting in Seattle, Washington, October 20-23, 2005. Discussion will include modifiers, possible sunset of category III codes, robotic surgery, online-consultations and construction of vignettes. Doctor Hollmann also informed the RUC that actions that come from this meeting, such as any code proposals that need to be considered for February, will need to be in the AMA office by November 7, 2005. The codes the RUC will be working on today will all be in the CPT 2007 cycle.

VI. CMS Update

- Doctor Ken Simon briefed the RUC that currently the agency has been engaged in the restorative efforts of Hurricane Katrina as well insuring that displaced evacuees have medical coverage and determining ways to re-establish and retain displaced physicians.
- Doctor Simon announced that September 16, 2005, was the last day for comment on the Outpatient Prospective Payment System and September 30, 2005, is the last day for comment on the Proposed Rule for the Physician Fee Schedule.
- The Final Rule on the Medicare Physician Payment Schedule is to be available on November 1, 2005.
- Currently, the agency is working with many specialty societies to develop performance indicators and measures for the Physician Voluntary Reporting Program (PVRP). PVRP is anticipated to be operational in 2006.
- The agency is waiting to see what possible Congressional actions will be taken regarding concerns to the SGR.

VII. CMD Update

Doctor William Mangold expressed that the Contractor Medical Directors as a group are committed to participate and provide assistance to the RUC to improve the process and procedures of the RUC.

VIII. Washington Update

Sharon McIlrath updated the RUC on the issues surrounding the SGR. Currently, the SGR decrease prediction is -4.4% cut in 2006, partly because a change in the MEI and volume changes. Virtually everyone agrees that payments can not be cut by 26%. It is evident that any SGR fix will be accompanied by some form of pay-for-performance requirement. CMS has sent out sixty to seventy quality indicators, which would be used in a large national demonstration that may be able to be implemented next year. The details on pay-for-performance plans are currently not fully developed. Sixty groups (specialties, AAMC, MGMA, AMGA, etc.) signed framework indicating that pay-for-performance is unacceptable if it is not accompanied by a repeal of the SGR, it must be voluntary, phased in and it must have positive updates for all physicians including those that do not participate. Currently there are two bills proposed, both call for public reporting and both include efficiency measures in addition to quality measures. The Nancy Johnson bill meets most of the AMA pay-for-performance principles and every physician whether or not they participated, would be better off than under current law. The other bill provides no such assurances and is not supported by the provider community.

MedPAC Update:

Kevin Hayes, from the Medicare Payment Advisory Commission, provided the RUC with an update in the Commission's activities. Mr. Hayes spoke about current reports and the Proposed Rule. There will be two reports to Congress, one in March 2006 and the other in June 2006. The goal is constructive recommendations on how to improve Medicare payment policy. The March report will include a recommendation on how the conversion factor for 2007 should change to account for inflation and other factors. The June 2006 report will address a number of issues concerning physician services and the possibility of some mis-pricing of services in the Physician Fee Schedule. The Commission has been concerned about growth in spending in areas such as imaging. The Commission will examine the two main elements of the Fee Schedule, other than the conversion factor, the relative value units and the geographic price cost indices (GPCIs). The Commission will be examining the work of the RUC and its recommendations to CMS, how CMS uses the RUC's recommendations and CMS independent activities. Regarding GPCI's, the Commission will be reviewing payment locality boundaries that have not been revised since 1997, how GPCI's work with services when equipment and supplies constitute a higher than average share of practice expense inputs for services.

IX. Relative Value Recommendations for CPT 2006

Ventricular Restoration (Tab 4)
John Conte, Society of Thoracic Surgeons (STS)/American Association for Thoracic Surgery

Due to advancements in technology that has allowed for standardization of the restoration of the ventricle, CPT created a new code to account for this type of procedure that is technically more complicated and involves different work than is described by current codes.

The presenters stated that the existing code 33542 *Myocardial resection (eg, ventricular aneurysmectomy)* (work RVU = 28.21) involves different work and does not accurately describe this procedure. The presenters stated that patients undergoing ventricular restoration are among the sickest patients with advanced heart failure with the average patient staying in the ICU post-operatively 4-5 days. The presenters stated that in about 80 to 90 percent of these patients, bypass surgery is also performed at the same time and it was explained that the recommended value does not include any of the bypass surgery work. However, since the reference code is included in the current five-year review the RUC assigned an interim value so that the code could be evaluated in comparison to a new value approved by the RUC in September, 2005. The current recommendation for code 33548 is based on the RUC approved STS five-year review alternative methodology.

The presenters explained that the interim relative value of 37.97 resulted in an IWPUT of 0.085, which was felt by the society to be too low in comparison to the recently evaluated five-year review codes. The E/M services assigned to the global period were also distorted by derivation from the Harvard assigned visits of the reference code. The reference code 33542 was refined by the RUC and has a RUC recommended value of 44.20 work relative values. Additionally, intra-service time, length of ICU and regular hospital stay, and duration of mechanical ventilation has been acquired for 33548 from the STS database, which recently added this new procedure to its procedure list. Code 33548 was also surveyed for intensity along with the other adult cardiac codes submitted for refinement. A comparison of the STS data and IWPUT between 33548 and 33542 for the period 2001-2004 is attached. It indicates that 33548 is significantly more intense in intra-service work, more complicated and is associated with significantly more postoperative management physician work (confirming the relationship between the two codes determined by the standard RUC survey) than the reference code.

In recommending a new value for 33548, the specialty considered the following factors:

1. Establishing the new value based on the ratio of refined 33542 and Harvard 33542, adjusting the RUC-approved value of 33548 proportionately. This results in a recommendation of ((44.20/28.21)*36.46) = 57.13
2. Establishing a new value through the utilization of data from the RUC survey performed for the April 2005 RUC meeting, data from the RUC approved reference code value, data from the STS national database, and intensity data from the survey that was used in the 5 year refinement process. This method led to a recommendation of 49.41. The new value includes an additional 99292 visit compared to the workgroup recommendations for the reference code, consistent with the additional ICU stay and ventilator hours for 33548 and consistent with several of our workgroup approved codes with similar ICU stay and ventilator hours. We maintained the RUC approved 99239 discharge for 33548, and this was consistent with other work group recommendations for similar codes. Otherwise, the number and level of the in-hospital visits are the same as for the reference code.

The presenters recommended the lower value, 49.41, for several reasons:

1. The higher value of 57.13 could only be "built" through increasing peri-operative time and E/M services to levels above even those recommended by our specialty for similar codes.
2. The higher value would create rank order anomalies with other procedures, should the refinement process interim results be finalized. For example, 33548 would have a higher work value than 33545 *Repair of postinfarction ventricular septal defect, with or without myocardial resection*, RUC recommended RVU = 52.49)
3. The value 49.41 is an appropriate relative value compared to the RUC recommended value for 33542 (44.20), and the relationships of intra-service time, IWPUT, and post-operative E/M services are consistent with STS national database data for both procedures.

The RUC agreed with this analysis and felt that the recommended values placed the code in proper rank order with the recently refined RUC recommended values for the adult cardiac codes values.

The RUC recommends a work RVU of 49.41 for code 33548.

Practice Expense

The RUC recommends the standard inputs for 90 day global procedures performed in the facility setting with the exception of using the RN staff type rather than the standard blend.

X. Relative Value Recommendations for CPT 2007

Abdominal Approach Revision of Prosthetic Vaginal Graft (Tab 5)
Robert Harris, MD – American College of Obstetricians and Gynecologists

As a result of an aging population, the incidence of complex pelvic surgery has increased. With this, surgical techniques have expanded and improved to include the use of prosthetic materials for vaginal reconstruction. As in any specialty, complications may occur with prosthetic materials thereby requiring revision or removal. Therefore, the CPT Editorial Panel created a new CPT code to address potential surgical problems associated with the use of new materials and new techniques and to accurately describe the work associated with a revision of a prosthetic vaginal graft performed with the open abdominal approach.

The RUC was presented with survey data from the American College of Surgeons and the American Urogynecologic Society. It was noted that although there were only 19 survey respondents, that this procedure is not very common and very few providers perform it. The specialty society stated that they felt the pre-service time was over-estimated and the post-service time was underestimated by the survey respondents when comparing this code to the reference code 57280 *Colpopexy, abdominal approach* (Work RVU=15.02). Therefore, the specialty society recommended and the RUC accepted that the pre-service time associated with this service should be decreased by 20 minutes and the pre-service time components should be as follows: 45 minutes pre-service evaluation time, 10 minutes pre-service positioning time and 10 minutes pre-service scrub/dress/wait time. In addition, the specialty society recommended and the RUC accepted that the post-service time be increased by 10 minutes to accurately reflect the work performed to result in 40 minutes of immediate post-service. The RUC assessed these new time increments and intensity/complexity measures of the surveyed code in comparison to the times and intensities/complexities of the reference code. The RUC noted that the physician times (405 total minutes for the surveyed code and 411 minutes for the reference code) and the complexity/intensity measures for these two codes are very similar. Therefore, the RUC agrees with the specialty society that the work RVU for this code should be the median surveyed value of 15.02 work RVUs. **The RUC recommends 15.02 work RVUs for 572XX1.**

Practice Expense
The RUC recommends the standard inputs for 90 day global procedures performed only in the facility setting.

Ultrasound Transplanted Kidney with Doppler (Tab 6)
Bibb Allen, Jr., MD – American College of Radiology (ACR)
Jonathan Berlin, MD - American College of Radiology (ACR)
Gary Seabrook, MD - Society for Vascular Surgery (SVS)

The CPT Editorial Panel deleted one code and created another to accurately reflect current medical practice and the physician work involved. The procedure of ultrasound of a transplanted kidney has changed since the with or without Doppler terminology was created. Ultrasound of a transplanted kidney without Doppler is an uncommon study today, however when performed it can be accurately reported by existing limited retroperitoneum code 76775 *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; limited* (2005 Work RVU = 0.58). Code 76778 *Ultrasound, transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler study* (2005 Work RVU = 0.74) was deleted by the Editorial Panel and the new code describes the performance of a complete ultrasound of the transplanted kidney which includes both real time imaging and duplex Doppler evaluation. The CPT Editorial Panel believed that by developing this new code would appropriately describe how ultrasound of the transplanted kidney is now typically performed and bring the coding for this procedure in line with other codes in CPT by deleting the "with and without" phrase.

The RUC reviewed the specialty society's survey results carefully and believed that the physician work for new code 7677X *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* was similar to existing codes 76778 *Ultrasound, transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler study* (2005 Work RVU = 0.74), and 78707 *Kidney imaging with vascular flow and function; single study without pharmacological intervention* (2005 Work RVU = 0.96). The RUC understood that the new code did not reflect new technology and therefore was subject to CMS's work neutrality rules, in addition, the specialty believed that the service of deleted code 76778 would be reported by 76775 2-5% of the time and 7677X 95-98% of the time.

The RUC also believed that there was some increment of additional physician work for the Doppler study and the more direct supervision of the technician for this procedure. The RUC also reviewed the combination of the physician work of add on code 93325 *Doppler echocardiography color flow velocity mapping* (2005 Work RVU = 0.07) and code 76775. After considering the work of the above mentioned codes, the specialty survey results, and work neutrality, **the RUC recommends a relative work value of 0.76 for new code 7677X.**

Practice Expense
The RUC reviewed the specialty society's practice expense recommendation for new code 7677X, and compared the direct practice inputs to code 76778. The specialty society and the RUC made minor changes to the clinical labor and medical supplies typically used in the procedure and recommends the attached inputs.

Stereotactic Radiation Treatment Delivery (Tab 7)
American Society of Therapeutic Radiation Oncology

The CPT Editorial Panel created two new codes for stereotactic-based radiation treatment for cranial lesions delivered in a single fraction as a complete course of treatment. The Panel combined two CMS G-codes; G0173 *Stereotactic radiosugery, complete course of therapy in one session* and G0243 *Multi-source photon stereotactic radiosurgery, delivery, including collimator changes and custom plugging, complete course of treatment, all lesions,* into their own single CPT codes. The treatment is delivered by either a linear accelerator (sometimes called linac radiosurgery) or a multisource cobalt-60 unit (sometimes referred to as the Gamma knife). These new codes were required to define the technical component of single fraction cranial SRS (i.e. stereotactic radiosurgery) complete course of treatment in one session for the two SRS technical modalities which are utilized. There is no physician work associated with these two new codes.

The RUC, the Practice Expense Review Committee, and the specialty society carefully reviewed the direct practice expense inputs for new codes 7741X1 *Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multi-source Cobalt 60 based* and 7741X2 *Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); linear accelerator based,* both agreed that the initial specialty recommendation included more clinical labor time than typically would occur for these procedures. The discussion of the workgroup is listed below and the full revised practice expense inputs are attached.

The RUC and the specialty society representatives reviewed each clinical labor activity line by line and made appropriate changes to reflect the typical patient encounter. In total the clinical labor time for 7741X1 was reduced from the specialty recommendation of 368 minutes to 266 minutes, and for 7741X2 was reduced from the specialty recommendation of 278 minutes to 191 minutes. Below are the details of the reductions in clinical labor time that were made to reflect the typical practice and current PERC standards. These reductions were unanimously agreed upon by the RUC and specialty society:

Pre-Service Clinical Labor Time:
The committee reviewed the pre-service activities and reduced the time to the standards and to the typical time reducing the total pre-service time from 13 minutes to 9 minutes. These reductions occurred in coordinating the pre-service activities and providing pre-service education/obtain consent.

Intra-Service Clinical Labor Time:
The committee spent significant time understanding the details of the clinical labor activities involved in the two services and reduced the intra-service time from 355 to 254 minutes for 7741X1 and from 305 to 179 for 7741X2. Reductions in time in the pre-service of the service period reflected a change to the PERC standards, and reductions in the intra- and post-service time of the service period reflected the typical patient.

Two clinical labor staff members are needed during the intra service period, an RT and a Medical Physicist. The activities of each staff member were broken out by the specialty society so that the committee understood each increment of time being spent during the treatment plan and treatment time periods. With the clinical labor detailed, the committee understood the treatment and the typical time spent performing the procedure. The typical time spent by the RT after a line by line analysis was reduced by 41 minutes to 71 minutes, and the Medical Physicist time was reduced by 38 minutes. The specialty society agreed with these reductions as they again thought through the steps of the treatment plan and delivery procedure. In addition, the committee agreed that the staff monitoring the patient after the procedure needed only 20 minutes rather than 30 minutes as they would be multi-tasking.

Post-Service Clinical Labor Time:
The RUC agreed that a phone call in the post service time period was needed and agreed to 3 minutes for this activity.

Medical Supplies and Equipment:
The RUC reviewed the medical supplies carefully for both new codes and agreed with the specialty recommended medical supplies. No changes to medical supplies were needed and are recommended to the RUC.

Equipment
The RUC reviewed and discussed the necessity and the cost of the very expensive equipment used for this procedure. The specialty society assured the RUC that the new and CMS listed equipment were required for the service.

The RUC identified these two codes as a new technology codes. Codes 7741X1 and 7741X2 need to be re-reviewed by the RUC based on new information which the specialty society will present how this information affects the original RUC recommendation once wide-spread use of the new technology occurs.

Continuous Bronchodilator Therapy (Tab 8)
American College of Chest Physicians (ACCP)
American Thoracic Society (ATS)

The CPT Editorial Panel believed that Continuous Bronchodilator Therapy (CBT) is a unique new procedure, which involves specialized equipment and intense monitoring and assessment by non-physician health care professionals. This new service differs from current CPT code 94640 *Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)* (XXX Global, Work RVU 2005 = 0.00) has a duration of approximately 10 minutes, whereas the continuous monitoring and or observation of patients receiving CBT is required. In addition, higher doses of medication and a large volume nebulizer are required for CBT.

The RUC reviewed the non-facility practice expense inputs carefully focusing on the typical patient encounter. The RUC understood that an evaluation and management service is typically billed on the same day as the CBT and that the service would not be performed in the facility setting. The RUC believed, and the specialty agreed, that the clinical labor time initially presented to the RUC was too high for the typical patient encounter. The RUC reduced specific clinical labor activity line items to recommend a total clinical labor time of 29 minutes for code 9464X1 *Continuous inhalation of aerosol medication for acute airway obstruction; first hour (For services of less than 1 hour, use 94640)* and 22 minutes for add on code 9464X2 *Continuous inhalation of aerosol medication for acute airway obstruction; first hour: each additional hour (List separately in addition to code for primary procedure).* A detailed spreadsheet shows a detailed allocation of the clinical labor time in the non-facility setting and no direct practice expense inputs in the facility setting.

Genetic Counseling (Tab 9)
American College of Medical Genetics (ACMG)

The CPT Editorial Panel created a new medical genetics and counseling code to be used by non-physician practitioners to adequately describe the clinical labor activities performed. Currently the procedure is performed but is frequently not billed for independently. The service could not be adequately described using existing evaluation and management codes. The CPT Editorial Panel created code 96XX1 *Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family* so that it would not be codable with initial encounter E/M codes.

The RUC reviewed in detail the direct practice expense recommendations for medical genetic counseling in the non-facility setting with the understanding that there would be no inputs in the facility setting. The RUC understood that the typical patient had cancer, and the RUC and the specialty society agreed on a reduction, from what the specialty originally recommended, in the pre and post service clinical labor time typically needed to perform the service. **To reflect the typical patient and to eliminate double counting in staff activities, the RUC recommends a total of 55 minutes to perform this service with 30 minutes of intra service face to face time. 25 minutes of the total time includes pre-service time and post-service on going patient management and follow-up.**

XI. Practice Expense Review Committee Report (Tab 10)

The Practice Expense Review Committee (PERC) met on September 29, 2005 to critically review practice expense (PE) recommendations for all new and revised codes on the RUC agenda. PERC members; Bill Moran, MD (Chair), James Anthony, MD, Joel V. Brill, MD, Neal H. Cohen, MD, Thomas A. Felger, MD, Gregory Kwasny, MD, Peter McCreight, MD, Tye Ouzounian, MD, and James B. Regan, MD, thoroughly reviewed each of the specialty society's practice expense recommendations, and after considerable discussion, and additional facilitation for some new codes, specialty society representatives and PERC members reached consensus on the direct practice expense inputs for each code.

XII. Five-Year Review Recommendations (Tab 11)

RUC Health Care Professionals Advisory Committee (HCPAC) Review Board

Mary Foto, OTR, updated the RUC regarding the Five-Year Review codes reviewed by the HCPAC. CMS requested that six podiatric codes be reviewed at the 2005 Five-Year Review. CMS selected codes 10060, 11040, 11041, 11042, 11730 and 29580 to be reviewed because these procedures have never been reviewed by the HCPAC (that is, Harvard RVUs are still being used, or there is no information).

The HCPAC agreed with the American Podiatric Medical Association (APMA) that there was compelling evidence due to a flawed methodology used in the previous Harvard valuation for all six podiatric codes. The HCPAC recommended increasing the work RVU for three codes, maintaining the work RVU for one code and decreasing the work RVU for two codes.

Ms. Foto also informed the RUC that per CMS' request, the HCPAC gathered PLI premium data. **The HCPAC believed that the yearly average PLI premium data per profession is accurate and will submit the data to CMS.**

The full report of the RUC HCPAC Review Board Report was accepted for filing and is attached to these minutes.

Workgroup 1 – Dermatology/Plastic Surgery

Doctor Barbara Levy presented Workgroup One's report and consent calendars to the RUC and explained that the workgroup reviewed approximately 57 codes from dermatology/plastic surgery. There were no extractions from the consent calendar for this workgroup. **The RUC unanimously approved the dermatology/plastic surgery workgroup report and its relative value recommendations. The final RUC recommendations are attached to these minutes.**

Workgroup 2 – Orthopaedic Surgery

Doctor Tuck presented Workgroup Two's report and consent calendars to the RUC and explained that the workgroup reviewed 108 codes. There were several extractions from the workgroup's report including:

27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft* (2005 Work RVU= 20.09)

27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (2005 Work RVU = 15.58)

27447 *Arthroplasty, knee, condyle and plateau;medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)* (2005 Work RVU= 21.45)

27647 *Radical resection of tumor, bone; talus or calcaneus* (2005 Work RVU = 12.22)

The four codes were extracted by the specialty which asked for a facilitation meeting. The RUC provided a facilitation committee meeting. The facilitation committee agreed with the workgroup that for codes 27130, 27236 and 27447, given the lack of survey data and uncertainty on how to adjust the existing value based on Harvard times and visits and lack of compelling evidence, the values for these codes should be maintained. However, the

facilitation committee recommended that the new physician time data should be utilized for these codes. **The RUC agreed with the facilitation committee and recommends utilizing the NSQIP physician times and maintaining the values of the following codes: 20.09 work RVUs for 27130, 15.58 work RVUs for 27236, 21.45 work RVUs for 27447 and 12.22 work RVUs for 27647.**

The facilitation committee also reviewed CPT code 27647 and after lengthy discussion recommends to refer code 27647 to CPT based on Medicare data and confusion about the meaning of the "radical resection." Medicare data indicates that podiatry is the typical provider of this service and an examination of the podiatry survey data resulted in a median RVU of 12.78 with significantly lower intra-service time; therefore there was not sufficient evidence to increase the value to the requested RVU of 20.00. The facilitation committee was concerned that the APMA data was based on a mini-survey that did not include an anchor code and a full RUC survey. In addition, the RUC was not convinced that the size of the typical tumor has changed for this procedure and the meaning of "radical" could mean have different meanings to different specialties. **The RUC agreed with the facilitation committee's recommendation to refer code 27647 to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.**

23200 *Radical resection of bone tumor; clavicle* (2005 Work RVU = 12.06)

23210 *Radical resection of bone tumor; scapula* (2005 Work RVU = 12.47)

23220 *Radical resection f bone tumor, proximal humerus;* (2005 Work RVU = 14.54)

24077 *Radical resection of tumor (eg, malignat neoplasm), soft tissue of upper arm or elbow area* (2005 Work RVU = 11.74)

24150 *Radical resection of tumor, shaft or distal humerus;* (2005 Work RVU = 13.25)

24152 *Radical resection of tumor, radial head or neck;* (2005 Work RVU = 10.04)

25077 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area*(2005 Work RVU = 9.75)

25170 *Radical resection for tumor, radius or ulna* (2005 Work RVU = 11.07)

27049 *Radical resection of tumor, soft tissue of pelvis and hip area (eg, malignant neoplasm)* (2005 Work RVU = 13.64)

27076 *Radical resection of tumor or infection; ilium, including acetabulum, both public rami, or ischium and acetabulum* (2005 Work RVU = 22.09)

27078 *Radical resection of tumor or infection; ischial tuberosity and greater trochanter of femur* (2005 Work RVU = 13.42)

27329 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area* (2005 Work RVU = 14.12)

27365 *Radical resection of tumor, bone, femur or knee* (2005 Work RVU = 16.25)

27615 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area* (2005 Work RVU = 12.54)

27645 *Radical resection of tumor, bone; tibia* (2005 Work RVU = 14.15)

27646 *Radical resection of tumor, bone; fibula* (2005 Work RVU = 12.64)

At the presentation to the RUC, a RUC member extracted the previous 16 codes and recommended they be sent to CPT for clarification of the term "radical resection" and "deep excision." and thereby possibly creating new codes that differentiate a tumor based on its size and depth: **The RUC agreed with this recommendation and recommends referring the preceding codes to CPT for further clarification.**

After addressing the above issues, the RUC approved the Orthopaedic Surgery Workgroup report and relative value recommendation without revision. The final RUC recommendations are attached to these minutes.

Workgroup 3 – Gynecology/Urology/Pain Medicine/Neurosurgery

Doctor Michael Bishop presented Workgroup Three's report and stated that the workgroup diligently reviewed 73 codes of which 43 were withdrawn. There were several extractions from the workgroup's report including:

50590 – Lithotripsy, extracorporeal shock wave

The Workgroup recommended and the specialty society agrees with the recommended work value of 9.08 work RVUs for this procedure. However, the specialty society disagrees with the Workgroup's recommendation for intra-service time. The workgroup felt that the 25th percentile/Median of the survey data, 45 minutes, was appropriate. The specialty society felt that 80 minutes, more accurately reflected the amount of intra-service time associated

with this procedure. Thus, the American Urological Association (AUA) extracted this code for discussion. The AUA explained that this procedure reflects a new technology being utilized and therefore included within the Five-Year Review. This new technology is patient/user friendly and very precise. Also, this technology is far less powerful and requires more time to use appropriately. They described their survey data as being bi-modal and those surveyees that had the older technology had less time and those surveyees with the new technology had more time. However, the new technology will rapidly become more dispersed in the future and it was mentioned that the PEAC reviewed this service in 2003 and based its recommendations on the new technology. It was suggested by a RUC member, taking into consideration the specialty society's comments as well as the survey data that the 75th percentile would be a more appropriate intra-service time. It was also noted that the 99231 visit was to be removed from this service as this procedure is primarily performed in the outpatient setting. **The RUC accepts 9.08 work RVUs and 60 minutes of intra-service time for 50590.**

52000 – Cystourethroscopy
52204 – Cystourethroscopy, with biopsy
55700 – Biopsy, prostate; needle or punch, single or multiple, any approach

These codes were extracted by a RUC member because there was some concern as to the compelling evidence to increase the value of these codes as the survey results indicated that there had not been a change in work in the last five years. The specialty society explained that they agree that there has not been a change in the work of these codes for the last five years, however, the only data that exists with these codes is from the original Harvard studies. Therefore, the data associated with these codes was established almost 10 years ago. The data collected by the specialty society for the Five-Year Review was thought to be more representative of the services currently performed. **The RUC accepts the Workgroup's recommendation of 2.23 work RVUs associated with 52000, 2.59 work RVU for 52204 and 2.58 work RVUs for 55700.**

61697 – Surgery of complex intracranial aneurysm, intracranial approach; carotid stenting
61700 – Surgery of simple intracranial aneurysm; intracranial approach; carotid circulation
61702 – Surgery of simple intracranial aneurysm; intracranial approach; vertebrobasilar circulation

These three codes were extracted for the same reason. In each of these codes, the specialty society recommended critical care visits (99291) be added to the post service. The Workgroup felt that this recommendation was not appropriate and that a high level hospital visit (99233) more accurately

reflected the post service associated with this service. The number of visits was maintained for all three codes by the Workgroup.

The specialty society felt that after reviewing their survey data that if the survey respondent did not select a critical care visit (99291) that they recommended 2 high level hospital visits (2-99233). Therefore, the specialty society would recommend changing the workgroup recommended visits to reflect their survey data by adding in the additional high level hospital visits and add the work RVU associated with these visits to the work RVU for the service. The specialty society recommends:

CPT Code	Workgroup Recommended Number of 99233 Visits	Specialty Society Recommended Number of 99233 visits	Work RVU Adjustment	Specialty Society Work RVU Recommendation
61697	1	2	1.51	58.82
61700	2	4	3.02	49.03
61702	1	2	1.51	55.79

This motion failed as there was some concern expressed by several RUC members regarding the payment policy aspects of billing 2-99233 visits on the same day. It was discussed that although billing 2 hospital visits on the same day is prohibited by CPT coding convention, it is not prohibited on the RUC survey instrument. There was a suggestion made that the RUC survey instrument should instruct the respondents to bill the prolonged care service codes to reflect additional time spent with a non-critically ill patient. This issue was referred to the Research Subcommittee.

Due to this discussion, a RUC member made a further recommendation and was supported by the specialty society that instead of equating a 99291 code with 2-99233 codes that perhaps it would be more accurate, after hearing a description of the post-op services provided, to equate the original specialty society's recommendation of a 99211 code with a 99233 and a 99356 Prolonged care in the inpatient setting. The recommendation would be the following:

CPT Code	Workgroup Recommended Number of 99233 Visits	RUC Member Recommended Number of Additional 99356	Work RVU Adjustment	Specialty Society Work RVU Recommendation
61697	1	1	1.71	59.02
61700	2	2	3.42	49.43
61702	1	1	1.71	55.99

The motion failed. As part of the parliamentary procedure, if a specialty society recommendation fails, the original workgroup recommendations must be voted upon. **The following Workgroup recommendations were accepted by the RUC:**

CPT Code	Workgroup Recommended Number of 99233 Visits	Workgroup Work RVU Recommendation
61697	**1**	**57.31**
61700	**2**	**46.01**
61702	**1**	**54.28**

61537 – Craniotomy with elevation of bone flap; for lobectomy, temporal lobe without electrocorticography during surgery
61538 – Craniotomy with elevation of bone flap; for lobectomy, temporal lobe with electrocorticography during surgery

The specialty society has requested to extract these codes from the consent calendar. These codes were withdrawn without prejudice by the specialty society during the Workgroup review of these codes. The specialty society felt they did not adequately present their compelling evidence during the August Workgroup Meetings and would like to extract these codes as they now have the compelling evidence to support a review of these codes. The RUC accepted the motion to allow these codes to be extracted from the Workgroup's consent calendar to be further reviewed by the workgroup and subsequently approved by the RUC.

The workgroup began by addressing the compelling evidence for these codes. The specialty societies stated that the reason why these codes were brought forward was because there is an anomalous relationship between these codes being valued and other codes within the craniotomy family. The specialty society felt that 61538 involved the most amount of physician work within this family and this is not reflected in its current evaluation. In addition, because 61538 was the key reference code when 61537 was reviewed by the RUC, there also exists a rank order anomaly for 61537 as well. The workgroup agreed with the specialty society that there was an anomalous relationship and thereby compelling evidence.

The workgroup reviewed the service times for 61537. The workgroup felt that the pre-service time needed to be adjusted to reflect the services being performed and to be consistent with other neurological surgery codes reviewed by the workgroup. The workgroup recommended and the societies agreed with the following times for pre-service – 60 minutes of pre-service evaluation time, 20 minutes of positioning time and 20 minutes of scrub, dress

and wait time. The workgroup accepted the specialty societies' recommended intra-service time and post-service time, 265 minutes and 45 minutes respectively, as they felt this time adequately reflects the services being performed. The workgroup reviewed the specialty societies' recommended post-operative visits and amended them to four-99231 visits, one-99232 visits and two-99213 office visits as they felt this more accurately reflected the post-operative care of the typical patient. The workgroup reviewed the recommended RVW for this procedure and agreed with the specialty society that 35.00 RVU, the 25th percentile, represents the amount of physician work associated with this code and produces an IWPUT of 0.098 which the workgroup and the specialty societies felt was appropriate. The workgroup recommends the 35.00 work RVUs for 61537. **The RUC recommends the workgroup recommendation of 35.00 work RVUs for 61537.**

The workgroup reviewed the service times for 61538. The workgroup felt that the pre-service time needed to be adjusted to reflect the services being performed and to be consistent with other neurological surgery codes reviewed by the workgroup. The workgroup recommended and the societies agreed with the following times for pre-service – 60 minutes of pre-service evaluation time, 20 minutes of positioning time and 20 minutes of scrub, dress and wait time. The workgroup accepted the specialty societies' recommended intra-service time and post-service time, 330 minutes and 45 minutes respectively, as they felt this time adequately reflects the services being performed. The workgroup maintained the specialty societies' recommended post-operative visits as the workgroup felt this accurately reflected the post-operative care of the typical patient. The workgroup reviewed the recommended RVW for this procedure and agreed with the specialty society that 38.00 RVU, the 25th percentile, represents the amount of physician work associated with this code and produces an IWPUT of 0.087 which the workgroup and the specialty societies felt that this value places this code in rank order within its family. The workgroup recommends the 38.00 work RVUs for 61538. **The RUC recommends the workgroup recommendation of 38.00 work RVUs for 61538.**

After addressing the above issues, the RUC approved the Gynecology/Urology/Pain Medicine/Neurosurgery Workgroup report and relative value recommendations without revision. Th RUC adopted the full report and consent calendar. The final RUC recommendations are attached to these minutes.

Workgroup 4 – Radiology/Pathology/Other Misc. Services

Doctor Zwolak presented Workgroup Four's report and consent calendars to the RUC and explained that the workgroup reviewed 80 codes. Of these 80 codes; 68 remained on the consent calendar, 8 were extracted and 4 had no consensus.

Ventilation Management - 94657

CPT code 94657 was extracted by a RUC member for discussion. The RUC first discussed workgroup extracted code 94657 and agreed with the workgroup that the code should be reviewed with its base code 94656 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day* (2005 Work RVU = 1.22). The specialty stated that the typical patient was more complex, however the RUC believed there was still a substantial portion of typical patient scenarios that are less complex and require less physician work. The RUC reviewed the specialty's survey results and rationale, and believed there is a bimodal patient distribution of procedure. **The RUC referred the specialty to the CPT Editorial Panel to have the code split into two distinct patient population specific codes.**

Spinal Fluid Tap - 62270

This code was extracted by the specialty society for discussion. The RUC heard from specialty society representatives that 1) the code was not appropriately valued by Harvard, and 2) at least in the pediatric population, there has been an increased level of complexity in the typical patient. The current RVW for code 62270 Spinal puncture, lumbar, diagnostic is 1.13. The specialty believed that the patient population had changed whereas the procedure is now more frequently performed on older children than in the past, apparently a more difficult cohort. The RUC noted that the Medicare utilization indicates the specialties that brought the code forward are infrequent providers of the service, but pediatrics provide a substantial number of these services outside the Medicare population. Medicare data indicates diagnostic radiology as the specialty most frequently billing this service but the American College of Radiology (ACR) although initially indicating a level 1 interest in the code changed to a level 2 interest. The ACR did later provide a comment letter supporting pediatrics' recommendation for an increase in the relative value.

Specialty society representatives and RUC members discussed the survey results and the level of physician work, in relation to similar procedures and similar work RVUs to establish the correct level of physician work for this spinal procedure. The RUC did believe that there had been an increase in the level of physician work for this service however, the RUC had difficulty accepting the median and the 25th percentile of the specialty society's survey results. The RUC believed that the level of physician work for code 62270 should not exceed the work of code *62284 Injection procedure for*

myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) (000 day global, work RVU 2005 = 1.54). In addition, the RUC and specialty society believed that the physician work was closer to, but not equivalent to, code *27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid* (000 day global, work RVU 2005 = 1.40; 10-25-5 minutes). **The RUC recommends a relative work value of 1.35 for code 62270** since the intra-time of 62272 is 5-minutes less than the reference. With this recommendation, the specialty agreed that a rank order anomaly would not be generated with code 62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter) (000 day global, 2005 work RVU = 1.35)

The physician time components were also discussed in light of the fact that an evaluation and management code is typically billed with 62270. The RUC recommends that the pre-service time be reduced from 25 minutes to 10 minutes. The RUC recommends the intra-service time of 20 minutes and immediate post time of 10 minutes from the specialty's survey results.

Cardiac Magnetic Resonance Imaging – 75552-75556

The cardiac magnetic resonance imaging family (75552-75556) was extracted by interested specialties. The American College of Cardiology and the American College of Radiology believed that the current CPT coding structure for Cardiac MRI (CPT codes 75552 - 75556) did not accurately reflect current practice and as a result is confusing to members of both societies as well as payers for the services. **The RUC agreed with the specialty's recommendation to send this Cardiac MRI family of codes to the CPT Editorial Panel for a revision in their CPT descriptor terminology.**

Electroencephalogram (EEG); including recording awake and asleep - 95819

Code 95819 was extracted by the American Academy of Neurology and was discussed by the full RUC. Specialty representatives maintained that since the technology had changed from an analog to a digital system, there had been an increase in the amount of physician work for the typical patient.

The RUC reviewed the specialty's survey results showing a requested change in the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. **The RUC recommends to maintain the current value of 1.08 RVUs. The RUC agreed with the physician time survey data and recommends all of the physician time elements.**

Pathology Consultations 88309 & 88321-88325

Code 88309 was extracted by the workgroup because of a math error when calculating its recommended RVU. The workgroup and the RUC discussed the error and its relationship with the 25th percentile survey results. The workgroup and the RUC agreed that the physician work had changed and that compelling evidence was established. The Workgroup amended its recommendation to the specialty's 25th percentile surveyed RVU of 2.80 and the RUC accepted the workgroup's recommendation. **The RUC recommends a work RVU of 2.80 for code 88309.**

The Workgroup recommended no consensus on code 88321, 88323 and 88325. The specialty society representatives first clarified to the RUC how the physician work had changed recently by describing the typical patient scenario for each of the three other extracted pathology consultations (88321, 88323, 88325). The RUC accepted the compelling evidence to consider a change in physician work. The change in work is due to the increased number and type of slides undergoing review in the typical case, and in particular, the number of immunohistochemical slides that must undergo review. The RUC also believed that the clinical practice of these pathology consultations have changed based on recent literature. The specialty society's survey results supported the specialty's contention that the physician work had increased.

The specialty's survey results indicated pathology consultations now take longer to perform, and require more work. After further clarification and discussion, the RUC and the specialty society agreed that the level of physician work equals the specialty's 25th percentile survey results. **The RUC therefore recommends the following relative value units and physician time components for codes 88321, 88233, and 88325, which represent the 25th percentile specialty society's survey results:**

Code	Current RVU	Recommended RVU	Current Intra-Service Time	Recommended Intra-Service Time
88321	1.30	**1.63**	41 minutes-Hrvd	**50 minutes**
88323	1.35	**1.83**	42 minutes-Hrvd	**56 minutes**
88325	2.22	**2.50**	69 minutes-Hrvd	**80 minutes**

Doppler Color Flow Add-On – 93325

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

Workgroup 5 – Evaluation and Management Services

Workgroup Members: Doctors Norman Cohen, John Derr, David Hitzeman, George Kwass, Gregory Pzybylski, and Maurits Wiersema

Workgroup Recommendations

99201	**0.45**	**99241**	**0.64**
99202	**0.88**	**99242**	**1.34**
99203	**1.34**	**99243**	**1.97**
99204	**2.03**	**99244**	**3.02**
99205	**3.00**	**99245**	**3.77**
99211	**0.17**	**99251**	**1.00**
99212	**0.45**	**99252**	**1.50**
99213	**0.80**	**99252**	**2.27**
99214	**1.30**	**99253**	**3.29**
99215	**2.00**	**99255**	**4.00**
99221	**1.88**	**99281**	**0.33**
99222	**2.56**	**99282**	**0.55**
99223	**3.78**	**99283**	**1.24**
99231	**0.76**	**99284**	**1.95**
99232	**1.30**	**99285**	**3.06**
99233	**2.00**	**99291**	**4.29**
99238	**1.28**	**99292**	**2.15**
99239	**1.90**		

Individuals Presenting for Specialty Society:

James Anthony, MD	**American Academy of Neurology**
Katherine Bradley, PhD, RN	**American Nurses Association**
Dennis Beck, MD	**American College of Emergency Physicians**
Doug Leahy, MD	**American College of Physicians**
Meghan Gerety, MD	**American Geriatrics Society**
Larry Martinelli, MD	**Infectious Disease Society**
Lee Mills, MD	**American Academy of Family Physicians**
Alan Plummer, MD	**American College of Chest Physicians**
Joseph Schlect, MD	**American Osteopathic Association**

The RUC member representing the American College of Surgeons extracted all of the Workgroup recommendations for consideration by the full RUC.

A coalition of medical specialty societies initially extracted the following 19 E/M codes for additional review by the RUC:

99204, 99205, 99213, 99214, 99215, 99231, 99232, 99233, 99244, 99245, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99291, and 99292.

Introductory Remarks and Discussion

Prior to discussion of each individual E/M code, the RUC considered the compelling evidence standard approved by the Workgroup for these codes. Doctor Cohen explained that the Workgroup concluded that compelling evidence standard applicable to these codes was that **"**Evidence that incorrect assumptions were made in the previous valuation of the service, as documented." This is consistent with the previous RUC recommendation and communications to HCFA following the 1st Five-Year Review. At this time, HCFA also indicated that that the agency would be willing to review new information to support the original RUC recommendations. The Workgroup utilized this compelling evidence to open the codes for discussion, while reviewing each individual codes on its own merit. The Workgroup did not find that the compelling evidence standards were met for either the Emergency Department services or the Critical Care codes. However, the Workgroup did recommend increases for critical care codes 99291 and 99292 to avoid rank order anomalies that would be otherwise be created with the new E/M increases.

The RUC approved the following motion:

The RUC agrees that the compelling evidence standards have been met for all E/M codes (except critical care and emergency medicine) under consideration. The application of the following compelling evidence standard allows discussion of each individual code on its own merit:

Evidence that incorrect assumptions were made in the previous valuation of the service, as documented.

The RUC also discussed the survey data collected by the surgical specialty societies. Doctor Cohen explained that the Workgroup considered the surgeons submission as a comment and obtained the specialty specific survey data on the day of the Workgroup meeting as information only. Doctor Rich clarified that any RUC member may share information on a particular issue, but requested that any documentation provided should be shared with all RUC members. Any materials to be distributed to RUC members should be provided to AMA staff in a timely fashion and should be distributed by AMA staff.

Doctor Cohen also provided clarification that IWPUT was not utilized to establish the relative value recommendations for E/M codes. This analysis

was only used to review the Workgroup's recommendations within and between families of E/M services to ensure relativity.

Doctor Leahy began his presentation by extending thanks to the Workgroup, his surgical colleagues, and AMA staff. He stated that as a group, the coalition of medical specialty societies wished to stress their support of the RUC process. He indicated that they wished to make the RUC stronger and did not wish to do any harm to the process. He acknowledged that there are other view points and indicated that they understood that the process must consider these viewpoints. Doctor Leahy then indicated that the coalition of medical specialties wished to extract 19 of the 35 Workgroup recommendations as they to argue that further increases were warranted. Doctor Leahy emphasized that the medical groups would continue to present evidence that the E/M services had increased in physician work over the past ten years. He shared data with the RUC to emphasize their arguments that:

- Chronic care management has become a larger portion of E/M services;
- Number of diagnosis per patient have increased;
- Number of medications have increased; and
- The length of hospital stay has decreased, leading to sicker patients in the outpatient setting.

The E/M codes were then discussed in the order requested by the medical specialty societies. The discussion will be listed here in CPT code order, with the date and time of the discussion noted.

Office Visits, New

The RUC reviewed the new office visits on Saturday, 5:30 - 6:30 pm. The medical specialties accepted the Workgroup recommendations for 99201, 99202, 99203, and 99205 (had dropped their earlier extraction of 99205).

<u>99201</u>

The RUC approved the Workgroup recommendation of 0.45 for 99201.

<u>99202</u>

The RUC approved the Workgroup recommendation of 0.88 for 99202.

<u>99203</u>

The RUC approved the Workgroup recommendation of 1.34 for 99203.

99204

The Workgroup had recommended 2.03 for this service. The medical specialties extracted this recommendation and requested consideration of a value of 2.50 based on their survey data. The motion to accept the value of 2.50 failed. A subsequent vote to accept the Workgroup recommendation of 2.03 also failed. A RUC member made a motion to consider 2.30, with a reference service of 99343 (work RVU, 2.27). This motion passed.

The RUC approved a recommendation of 2.30 for 99204.

99205

The RUC approved the Workgroup recommendation of 3.00 for 99205.

Office Visits, Established Patient

The established office visits were discussed on 7:30 pm - 10:00 pm on Saturday and 10:30 am - 11:00 am on Sunday.

99211

The specialty and the E/M Workgroup did not recommend a change in the work relative value for this code. **The RUC recommends a work relative value of 0.17 for 99211.**

99212

The specialty and the E/M Workgroup did not recommend a change in the work relative value for this code. **The RUC recommends a work relative value of 0.45 for 99212.**

99213

The Workgroup recommendation for 99213 was 0.80. The medical specialty societies extracted this code for further discussion and requested that the RUC consider a work relative value of 1.20 for this service. The specialties provided a number of reference services to consider with total time of 25-30 minutes, including 70544 (1.20) and 31231 (1.10). Other RUC members indicated that there were other services with similar time, with lower values, including 99347 (0.76) and 76005 (0.60). A motion to approve the specialty recommendation of 1.20 failed. A subsequent motion to approve the Workgroup recommendation of 0.80 also failed. A review of the ballots

indicate that 2/3 of the RUC agree that the work relative value should be at or above the Workgroup recommendation of 0.80.

A RUC member made a motion to value 99213 at 1.00. The specialty argued that 1.00 was appropriate relative to other services, such as echocardiography, colostomy, and simple skin biopsy. Other RUC members expressed concern that the intensity of 99213 would not be higher than 99203 and that although IWPUT was not being used to determine the value of these codes, a comparison across families and within families was appropriate. It was noted a large 100% increase in the IWPUT between 99212 (RUC approved at 0.45, IWPUT = 0.27) and 99213 (specialty recommendation of 1.00, IWPUT = 0.52) is also not appropriate. The motion to recommend 1.00 for 99213 failed (13 in favor, 13 opposed).

The RUC postponed discussion of 99213 to allow further review, discussion, and reflection prior to the February 2006 RUC meeting.

99214

99214 was not discussed during the course of the meeting. The RUC action to postpone discussion on 99213 and 99215 also incorporated 99214. **The RUC postponed discussion of 99214 until the February 2006 meeting.**

99215

The Workgroup recommendation for 99215 was 2.00. The medical specialty societies extracted this code for further discussion and requested that the RUC consider a work relative value of 2.35 for this service. The specialty argued that this service should be valued slightly higher than 99204, approved at 2.30. RUC members expressed concern that this request would reflect a higher intensity for a follow-up visit as compared to a new office visit. A motion to approve 2.35 failed (15 in favor, 11 opposed).

The RUC then voted on the Workgroup recommendation of 2.00. This motion also failed. However, more than 2/3 of RUC members agreed that the work value for 99215 should be at or above 2.00.

A motion was made by a RUC member to value 99215 at 2.30. This motion also failed (12 in favor, 14 opposed).

A motion was made by a RUC member to value 99215 at 2.17. This motion also failed (9 in favor, 16 opposed).

A motion was made again to approve the Workgroup recommendation of 2.00. Individuals voiced objection again right before the vote and indicated

that they would propose a recommendation of 2.15 next. The motion for 2.00 subsequently failed (13 in favor, 13 opposed).

A final motion was made to value 99215 at 2.15, the 25% of the survey data where the endocrinology data is removed. This motion also failed (15 in favor, 11 opposed).

Several RUC members expressed concern that many of the above motions for values were made without the same level of rationale and justification as the original Workgroup recommendation of 2.00.

The RUC postponed discussion of 99215 to allow further review, discussion, and reflection prior to the February 2006 RUC meeting.

Initial Hospital Visits

The initial hospital visit codes were discussed on Sunday, 7:00 am - 7:30 am. The medical specialty society did not extract any of these services for discussion. Doctor Gage extracted all three codes as a RUC member.

This was the first family of codes to be discussed on Sunday morning and a RUC member mentioned that due to the lack of time to sufficiently discuss each issue, the RUC should consider labeling the recommendations interim if a quick resolution could not be made on each individual code.

A motion to approve the Workgroup recommendation for all codes 99221 - 99223 failed (13 in favor, 13 opposed). A decision was then made to review the family on a code-by-code basis.

<u>99221</u>

A motion to approve the Workgroup recommendation of 1.88 was approved. **The RUC recommends a work relative value of 1.88 for 99221.**

<u>99222</u>

A motion to approve the Workgroup recommendation of 2.56 initially failed and then was approved as an interim recommendation. **The RUC recommends a work relative value of 2.56 for 99222 as an interim recommendation.**

<u>99223</u>

A motion to approve the Workgroup recommendation of 3.78 initially failed and then was approved as an interim recommendation. **The RUC recommends a work relative value of 3.78 for 99223 as an interim recommendation.**

Subsequent Hospital Visits

The subsequent hospital visits were discussed on Sunday, 8:15 am - 8:45 am.

The medical specialties indicated that they were extracted all three codes in this family.

99231

The medical specialty societies requested that their median survey value of 1.00 be considered for 99231. This motion failed. The Workgroup recommendation of 0.76, based on a comparison to CPT code 99347, was considered by the RUC and the motion to approve this recommendation was approved. It was noted that in the first Five-Year Review, the RUC recommended that 99213 should reflect a higher work value than 99231 and the Workgroup's recommendations are consistent with these earlier actions.

The Workgroup recommendation of 0.76 for 99231 was approved by the RUC.

99232

The Workgroup recommendation for this service was 1.30. The medical specialty requested that the RUC consider a work relative value of 1.60. A motion to consider 1.60 failed (12 in favor, and 14 opposed). A motion to consider the Workgroup recommendation of 1.30 also failed. A RUC member then made a motion that the RUC consider the 25th percentile of 1.50 for 99232. This recommendation also failed (14 in favor and 12 opposed). It was noted that the RUC recommended 1.30 for 99232 in the first Five-Year Review. The RUC considered another motion to approve 1.30 as an interim recommendation. This motion was approved.

The Workgroup recommendation of 1.30 for 99232 was approved by the RUC as an interim recommendation.

99233

The Workgroup recommendation for this service was 2.00. The medical specialty requested that the RUC consider a work relative value of 2.50 and compared the service to 36010 (work RVU = 2.43; 26 minutes total time). A motion to consider the 2.50 failed. A motion to consider the Workgroup recommendation also failed. A motion to consider 2.00 as an interim recommendation was approved.

The Workgroup recommendation of 2.00 for 99233 was approved by the RUC as an interim recommendation.

A RUC member stated that the RUC should have a conversation in February regarding the potential need for CPT to consider if three levels of E/M is appropriate for hospital services.

Hospital Discharge

The hospital discharge codes were discussed on Sunday, 7:30 am - 7:45 am.

The medical specialties did not extract these services. Doctor Charles Mabry indicated that he had not intended to extract these two codes.

99238

The Workgroup recommendation of 1.28 for 99238 was approved by the RUC.

99239

The Workgroup recommendation of 1.90 for 99239 was approved by the RUC.

Outpatient Consultations

The RUC initially voted on the entire family of outpatient consultation codes as one vote (Saturday, 8am). The vote was 16 in favor, and 10 opposed. As the vote was one shy of a 2/3 majority, a detailed discussion of each code ensued during the course of the meeting at the following days/times:

Saturday, 8 am - noon;
Saturday, 4:30 - 5:30 pm; and
Saturday, 6:30 - 7:30 pm

99241

Doctors Gage and Mabry extracted this code for discussion and argued that the work had not changed for this code. In addition, they expressed concern that such a large percentage of survey respondents were from endocrinology. **The RUC approved the Workgroup recommendation of 0.64 for this 99241.**

99242

Doctors Gage and Mabry extracted this code for discussion and argued that the work had not changed for this code. In addition, they expressed concern that such a large percentage of survey respondents were from endocrinology. **The RUC approved the Workgroup recommendation of 1.34 for this 99242.**

99243

Doctors Gage and Mabry extracted this code for discussion and argued that the work had not changed for this code. In addition, they expressed concern that such a large percentage of survey respondents were from endocrinology. A vote to approve this individual code at the Workgroup recommendation of 1.97 failed. A motion was then made that this code should be valued the same as CPT code 99386 at a work RVU of 1.88. This motion also failed. Later, the recommendation of 1.88 was reconsidered and approved. **The RUC approved a recommendation of 1.88 for 99243.**

99244

The medical specialties agreed with the Workgroup recommendation of 3.02. However, they did not agree with the Workgroup recommendation to increase the median survey time of 45 minutes to the 75% of 60 minutes. Initially, the specialty withdrew its objections. However, after extensive discussion, the RUC agreed with the medical specialties that the survey median of time 45 minutes should be utilized. A vote to approve the Workgroup recommendation of 3.02 initially failed and then was approved later with the adjustment of time and a comparison to the approved value of 3.00 for 99205. **The RUC approved the Workgroup recommendation of 3.02 for this 99244.**

99245

The medical specialties agreed with the Workgroup recommendation of 3.77. However, they did not agree with the Workgroup recommendation to increase the median survey time of 60 minutes to the 75% of 75 minutes. Initially, the specialty withdrew its objections. However, after extensive discussion, the RUC agreed with the medical specialties that the survey median of time 60 minutes should be utilized. A vote to approve the Workgroup

recommendation of 3.77 initially failed and then was approved later with the adjustment of time. **The RUC approved the Workgroup recommendation of 3.77 for this 99245.**

The detailed recommendations for all of the E/M services are attached to these minutes.

Inpatient Consultations

The inpatient consultations were discussed on Sunday from 7:45 am - 8:15 am.

Doctor Mabry indicated that he was not extracting 99251 and 99252. The medical specialties indicated that they only planned to extract 99555.

99251

The RUC approved the Workgroup recommendation of 1.00 for 99251.

99252

The RUC approved the Workgroup recommendation of 1.50 for 99252.

99253

The RUC approved the Workgroup recommendation of 2.27 for 99253

99254

A RUC member recommended that the median survey time of 50 minutes be utilized, rather than the 75th percentile time of 65 minutes, as recommended by the Workgroup. The specialty and the full RUC agreed with this recommendation.

The RUC approved the Workgroup recommendation of 3.29 for 99254.

99255

A RUC member recommended that the median survey time of 60 minutes be utilized, rather than the 75th percentile time of 75 minutes, as recommended by the Workgroup. The specialty and the full RUC agreed with this recommendation.

The specialty requested that the RUC consider a work relative value of 4.25 for 99255 and compared the work for this service to 99236 (work RVU = 4.26, total time of 110 minutes). A motion to recommend 4.25 for 99255

failed. A subsequent motion to approve the Workgroup recommendation of 4.00 was approved.

The RUC approved the Workgroup recommendation of 4.00 for 99255.

Critical Care

The critical care services were considered on Sunday, 8:45 am - 9:00 am.

The E/M Workgroup recommended that there was no compelling evidence that the critical care services were under-valued. However, due to the Workgroup's actions on other E/M families, adjustments were required in the critical care services to avoid rank order anomalies. The Workgroup recommended 4.29 for 99291 and 2.15 for 99292. The medical specialties extracted 99291 and 99292 and requested that the survey medians of 5.10 for 99291 and 2.66 for 99292 be approved.

The presenters argued that there has been a change in the patient population for these services and technology has also contributed to an increase in work. The specialty also indicated that they were concerned that codes 99223 (3.78), 99245 (3.77), and 99255 (4.00) were now valued close to the critical care services and 99291 should reflect a significant increase in work.

The specialty did not object to the method used to initially value these codes in the first Five-Year Review. Therefore, the Workgroup only considered these codes to prevent rank order anomalies. It is unclear from specialty society statements if they do believe that this building block method (four 99213 + ventilation mgt 99656 + chest x-ray) is inappropriate.

A motion to consider the specialty request of 5.10 for 99291 and 2.66 for 99292 was not approved. A motion to consider the Workgroup recommendation of 4.29 for 99291 and 2.15 for 99292 also failed. A motion to consider the Workgroup recommendations as interim was approved.

The RUC approved the Workgroup recommendation of 4.29 for 99291 and 2.15 for 99292.

Emergency Department Services

The Emergency Department services were reviewed on Sunday, 9:00 am - 10:00 am. The medical specialties extracted all five of these codes for further review.

The presenter first articulated that the compelling evidence to consider the emergency department services was based on a rank order issue. When these

services were first reviewed in the first Five-Year Review, the RUC recommended the following linkages:

99281 = 99201; 99282 = 99202; 99283 = 99203; 99284 = more than 99204; 99285 = more than 99205. The presenter recommended the same linkages for 99281 and 99282, but recommended that 99283 = 99243; 99284 = 99244; and 99285 = 99255. The presenter indicated that these values associated with these linkages would be consistent with the values between the 25th percentile and survey medians.

99281

The RUC agreed with the previous relationship established between 99281 and 99201. A motion to approve 0.45 for 99281 was approved.

The RUC approved a recommendation of 0.45 for 99281.

99282

The RUC agreed with the previous relationship established between 99282 and 99202. A motion to approve 0.88 for 99282 was approved.

The RUC approved a recommendation of 0.88 for 99282.

99283

The RUC considered a motion to approve the specialty society recommendation that 99283 be valued the same as 99243 (1.88). The motion was not approved. The RUC then considered a motion to use the existing RUC crosswalk of 99283 to 99203 (1.34). A motion to value 99283 at 1.34 was approved.

The RUC approved a recommendation of 1.34 for 99283.

99284

The RUC considered a motion to approve the specialty society recommendation that 99284 be valued the same as 99244 (3.02). This motion was not approved. The RUC than considered a motion to value 99284 at the survey 25th percentile of 2.56 (which is greater than 99204 = 2.30). A motion to value 99284 at 2.56 was approved.

The RUC approved a recommendation of 2.56 for 99284.

99285

The RUC considered a motion to approve the specialty society recommendation that 99285 be valued the same as 99255 (4.00). This motion was not approved. The RUC than considered a motion to value 99285 at the survey 25th percentile of 3.80 (which is greater than 99205 = 3.00). A motion to value 99284 at 3.80 was approved.

The RUC approved a recommendation of 3.80 for 99285.

Concluding Remarks on Evaluation and Management

Doctor Rich announced that the a few RUC members would be selected to join the original E/M Workgroup to resolve the three postponed codes and the six codes with interim values prior to the February 2006 RUC meeting. The following individuals are to participate in the E/M Workgroup: Doctors Norman Cohen (Chair), John Derr, William Gee, David Hitzeman, George Kwass, Douglas Leahy, Charles Mabry, Greg Pzybylski, J. Baldwin Smith, and Maurits Wiersema.

Workgroup 6 – Cardiothoracic Surgery

Doctor James Borgstede presented Workgroup Six's report and stated that the Workgroup reviewed 81 cardiothoracic surgery codes which can be further separated into three categories, congenital codes, adult cardiac codes and general thoracic codes. All 81 codes were extracted by the American College of Chest Physicians (ACCP) for discussion. The three reasons in which all codes from Workgroup Six were extracted were issues surrounding sufficient compelling evidence, appropriateness of the evaluation of work and time and appropriate valuation of the post-operative services, such as critical care.

The RUC discussed compelling evidence in lengthy detail and ultimately felt that the issue of compelling evidence for the congenital codes was met due to the existence of rank order anomalies. The RUC accepted that the patient population for the adult cardiac and general thoracic codes had changed in the last five years. The RUC considered evaluating the compelling evidence on a code by code basis for the adult cardiac and general thoracic codes, but instead determined that since the RUC already approved the STS building block methodology, the RUC would not examine the compelling evidence for each code. Rather the RUC accepted the previous RUC approval of the STS methodology as compelling evidence for each code.

The RUC extensively discussed the appropriateness of the evaluation of work and time by the workgroup. ACCP questioned the use of means instead of medians and length of stay differentiation between the STS database and the RUC database for the adult cardiac and general thoracic codes. The RUC considered the two intensity measures, the magnitude estimation of intensity

survey and the RASCH analysis of intensity, using the STS database. The RUC agreed that the blended measure of intensity was a fair representation of the intensity of the intra-service period.

The RUC accepted that Workgroup Six thoroughly reviewed all data elements for each code on a code by code basis. The Workgroup spent a great deal of time examining the work performed by the operating surgeon and agreed that a critical care visit should be used in the STS building block methodology. The assignment of the level of critical care services was recommended for each code based on the STS expert panel's knowledge and experience in caring for these patients, within the framework of duration of mechanical ventilation and the length of ICU stay provided by appropriate data in the STS database. The RUC accepted the valuation of the critical care visits by the Workgroup.

After addressing the above issues, the RUC approved the Cardiothoracic Surgery Workgroup report and relative value recommendations without revision, which included accepting the workgroup's majority recommendation for the 'no consensus' codes. The final RUC recommendations are attached to these minutes.

Workgroup 7 – General Surgery/Colorectal Surgery/Vascular Surgery

Doctor J. Baldwin Smith presented Workgroup Seven's report and stated that the workgroup diligently reviewed 106 codes of which 16 were withdrawn. Doctor Smith gave a brief introduction of the alternative methodologies employed by the specialty societies in their recommendations to the workgroup including the National Surgical Quality Improvement Project (NSQIP) data and the mini-survey data.

The NSQIP was started by the VA for quality improvement purposes but now includes a large volume of surgical procedures from non-VA hospitals as well. The NSQIP database contains intra-service times and length of stay data. The ACS proposed a building block methodology that would use a consensus panel to assign pre service times, immediate post service times as well as IWPUT estimates. The intra-service times would be the median times from the NSQIP database. The NSQIP database length of stay will be used by the expert panel to develop number and level of hospital visits. The expert panel will also develop number and level of office visits based on comparisons to codes requiring similar physician work.

Overall, where the NSQIP time and length of stay data was available, the Workgroup felt that for these few procedures, the physicians responding to the survey underestimated their intra-service time and therefore the Workgroup felt that the NSQIP data more accurately reflected the intra-service times for

these procedures. For the remaining procedures, the workgroup reviewed the survey data and typically agreed with the survey median intra-service times and work with some notable exceptions where the workgroup disagreed with these inputs as they felt did not reflect the service. In addition, the workgroup, when reviewing these procedures, recommended standardized inputs for pre-service elements including 30 minutes of evaluation, 15 minutes of positioning and 15 minutes of scrub, dress and wait to most procedures unless otherwise specified.

There were several extractions from the workgroup's report including:

35081 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm , and associated occlusive disease, abdominal aorta
35102 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)
35556 Bypass graft, with vein; femoral-popliteal
35566 Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels
35583 In-situ vein bypass; femoral popliteal
35585 In-situ vein bypass; femoral-anterior tibial, posterior tibial or peroneal artery

For codes 35102, 35556, 35566, 35583 and 35585 the workgroup reviewed the NSQIP data and the survey data in regard to the intra-service times. The workgroup agreed that the survey data demonstrated physicians underestimating their time and thus the NSQIP time was more accurate. Therefore to derive the recommended work RVU, the RUC determined the difference in time between the NSQIP and the survey data and multiplied this difference by a recommended IWPUT. The workgroup then added this resultant work to the median surveyed RVU. In addition, for all of the above codes, further adjustments in the resultant work were made based on modifications to the pre-service times. This methodology was criticized by the full RUC as a "mix and match" methodology utilizing various components of alternative methodologies to create one recommendation. Due to this utilized methodology, there were some RUC members who questioned the validity of the Workgroup's recommendations. In addition, there were varying opinions about whether the pre-service time and resultant work should have been removed from the total work RVU from all of the aforementioned codes. Therefore, the specialty society requested that the original specialty society recommendation, with slight modifications in work to account for modified pre-service times, be accepted as this methodology was solely based on NSQIP data. The specialty society recommended the following:

CPT Codes	Specialty Society Recommendations
35081	34.40 RVUs
35102	39.65 RVUs
35556	27.25 RVUs
35566	32.00 RVUs
35583	28.25 RVUs
35585	32.00 RVUs

The specialty society recommendation was divided by the RUC. For 35081, The RUC reviewed the recommended RVU and the survey median work RVU and the survey median intra-service time. A motion was made to accept the specialty society's recommendation for 35081. This motion failed. The RUC then considered the workgroup's recommendation of the surveyed median value and intra-service times and felt that that the surveyed median work and intra-service time is appropriate, as compared to the reference code, 35646 Bypass graft, with other then vein; aortobifemoral (Work RVU=30.95) properly places this procedure amongst the family. **Therefore, the RUC recommends 31.00 work RVUs for 35081**.

For 35102, the RUC reviewed the specialty society recommendation. A motion was made to accept the specialty society's recommendation for 35102. This motion failed. The RUC then considered the workgroup recommendation of 36.28 work RVUs and the NSQIP intra-service times for 35102 as part of parliamentary procedure. Discussion of this motion led to the discovery of further support for the workgroup's recommendation in the form of an additional reference code 35531 Bypass graft, with vein; aortoceliac or aortomesentric (Work RVU = 36.15) which had similar intensities, work and service times to the surveyed code. **Therefore the RUC recommends 36.28 work RVU for 35102.**

For 35556, the RUC reviewed the intensity, mental effort, technological skill associated with this procedure and agreed with the specialty society recommendation that the 75th percentile of the survey data, 27.25 accurately reflects the work associated with this code. **The RUC recommends 27.25 work RVUs for 35556.**

For 35566, the RUC reviewed the intensity, mental effort, technological skill associated with this procedure and agreed with the specialty society recommendation that the 75th percentile of the survey data, 32.00 accurately reflects the work associated with this code. **The RUC recommends 32.00 work RVUs for 35566.**

For 35583, the RUC reviewed the intensity, mental effort, and technological skill associated with this procedure and ascertained the specialty society's recommendation of the 75th percentile of the survey data, 28.25. A motion

was made to accept the specialty society's recommendation of 28.25. This motion failed. The Workgroup suggested an alternative recommendation of the median survey data, 26.00 work RVUs. The RUC reviewed the intensity, mental effort and technological skill associated with this procedure and felt that the median value of the survey data, 26.00 accurately reflects the work associated with this code. **The RUC recommends 26.00 work RVUs for 35583.**

For 35585, the RUC reviewed the intensity, mental effort, technological skill associated with this procedure and agreed with the specialty society recommendation that the 75th percentile of the survey data, 32.00 accurately reflects the work associated with this code. **The RUC recommends 32.00 work RVUs for 35585.**

It was noted that all of the aforementioned codes, would be utilizing the NSQIP times for intra-service and post-op visits.

An issue was raised by Doctor Simon of CMS questioning the ability of workgroup members and specialty societies to utilize data from several sources to establish their recommendations for the Five-Year Review. It was clarified that the Society of Thoracic Surgery did not utilize data from several sources that they used their database used for their alternative methodology. For Workgroup Seven, there were 12 codes where NSQIP time will be used in the RUC database and for those 12 codes the workgroup was convinced that the NSQIP data was more accurate than the survey data due to the large sample size that the NSQIP data provided.

It was then noted that there were three additional codes that utilized this "mix and match" methodology. Although the RUC agreed that these values appropriately placed these codes in rank order, the RUC requested additional rationale to further support these values. These codes and rationales are as follows:

44120 Enterectomy, resection of small intestine; single resection and anastomosis
44130 Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy
47600 Cholecystectomy;

The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population. The RUC reviewed each input and made a number of changes to standardize the pre-service times and accepted the NSQIP intra-service time and post-operative visits. The RUC reviewed the service times and post-operative visits for the reference service code for this procedure, 43631 Gastrectomy, partial, distal; with gastroduodenostomy (Work RVU=22.56). The RUC noted that the

reference code has 150 minutes of intra-service time while the surveyed code has 134 minutes of intra-service time. In addition, the RUC noted that the only difference between the post-operative visits between these two codes is that the reference code has 2-99232 and 5-99231 hospital visits while, the surveyed code has 2-99233, 2-99232 and 4-99231. To account for these differences, and to maintain rank order between the surveyed and reference code the RUC recommends a value of 20.11 work RVUs for 44120, which is a value precisely between the median and 75th percentile survey values. **The RUC recommends 20.11 work RVUs for 44120.**

The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population. The RUC reviewed each input and made a number of changes to standardize the pre-service times and accepted the NSQIP intra-service time and post-operative visits. The RUC reviewed the service times and the post-operative visits for the reference service code for this procedure, 43631 Gastrectomy, partial, distal; with gastroduodenostomy (Work RVU=22.56). The RUC noted that the reference code has 150 minutes of intra-service time while the surveyed code has 131 minutes of intra-service time. In addition, the RUC noted that the only difference between the post-operative visits between these two codes is that the reference code has 2-99232 and 5-99231 hospital visits while, the surveyed code has 1-99233, 1-99232 and 5-99231. To account for these differences, and to maintain rank order between the surveyed and reference code the RUC recommends the 20.87 work RVUs, which is slightly below the 75th percentile. In addition, this value keeps proper rank order between 44120 *Enterectomy, resection of small intestine; single resection and anastomosis* (RUC recommended work RVU 20.11) and 44130, as 44130 is deemed to be more intense that 44120 based on survey intensity. **The RUC recommends 20.87 work RVUs for 44130.**

The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population. The workgroup reviewed each input and make a number of changes to standardize the pre-service times and accepted the NSQIP intra-service time and post-operative visits. The RUC reviewed the service times and the post-operative visits for the reference code for this procedure, 47605 Cholecystectomy; with cholangiography (Work RVU=14.67). The RUC noted that the reference code has 90 minutes of intra-service time while the surveyed code has 115 minutes of intra-service time. In addition, the RUC noted that the only difference between the post-operative visits between these two codes is that the surveyed code has one additional 99231 hospital visit in comparison to the reference code. To account for these differences, and to maintain rank order between the surveyed and reference code the RUC recommends a value of 15.88 work RVUs for 47600, which is a value slightly above the 75th percentile. **The RUC recommends 15.88 work RVUs for 47600.**

47562 *Laparoscopy, surgical; cholecystectomy*

A RUC member extracted 47562 because of several concerns. The first concern is that with the amount of work RVUs being recommended by the Workgroup, 12.00 work RVUs, for this code, an anomalous relationship would be created amongst the spectrum of intensity of laparoscopic codes. The RUC member stated that this value may not be appropriate as it is his perception that surgeons have become much more comfortable performing laparoscopic surgeries over the last 15 years. The second concern raised was regarding the amount of intra-service time recommended by the workgroup, 80 minutes. The RUC member stated that in his experience, 60 minutes was a more accurate intra-service time. The third concern raised whether the issue of familiarity with new technology that occurs over time would be applicable as this technology becomes more dispersed over time the intensity of this procedure would presumably decrease. The fourth concern was the allocation of a full discharge day management to this service considering that more than 50% of these procedures are performed in an outpatient hospital or ASC setting. A more appropriate allocation for this procedure would have been a half a discharge day management service.

After a brief discussion of RUC members as well as specialty society representatives, a motion was made to accept the Workgroup's recommendation of 12.00 work RVUs as part of parliamentary procedure. This motion failed. The RUC felt that there was no compelling evidence that the current relative value is inappropriate due to evidence that incorrect assumptions were made in the previous valuation of the service. The RUC reviewed the surveyed times for this procedure and felt that the NSQIP time of 80 minutes most accurately reflected the intra-service time for this procedure. However, because this procedure is primarily performed in the outpatient setting, the RUC recommends a half day discharge management service, 99238. As a full discharge day management was recommended by the society, removing the work associated with a half a discharge day management from the specialty society's recommended value is approximately the existing value associated with this code. **Therefore, the RUC recommends to maintain the value currently associated with 47562, 11.07 work RVUs**.

47760 *Anastomosis of extrahepatic biliary ducts and gastrointestinal tract*

For 47760, the Workgroup had achieved consensus on its recommendation for this procedure of 34.75 work RVUs. Therefore, the workgroup would like to change the Action Key for this code from Action Key 7 *No Consensus* to Action Key Item 4 *Suggest a New Value* for acceptance of the workgroup recommended value.

After addressing the above issues, the RUC approved the General Surgery/Colorectal Surgery/Vascular Surgery Workgroup report and relative value recommendations without revision. The final RUC recommendations are attached to these minutes.

Workgroup 8 – Otolaryngology/Ophthalmology

Doctor Bernard Pfeifer presented Workgroup Eight's report and stated that the workgroup reviewed 60 otolaryngology and ophthalmology codes. Doctor Pfeifer indicated that there was one correction to the consent calendar: CPT code 41145 specialty society work RVU should read as 34.00, in which the workgroup recommended to adopt the specialty society's recommended increase in the work RVU.

CPT code 69210 *Removal impacted cerumen (separate procedure), one or both ears* was extracted for discussion. A RUC member extracted CPT code 69210 to validate that there is data present to raise the work RVU. The RUC did not agree with the specialty society that the patient population has changed to a more complex population for code 69210. The RUC also noted that the survey was completed by a specialty society, AAO-HNS, who perform this procedure less than 50 percent of the time. This issue was problematic for the RUC. **The RUC recommends to maintain the current value of this service (work RVU=0.61), which the RUC felt was justified by the survey in which 94% of respondents indicated that the work in performing this service has not changed in the past five years.**

CPT code 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)* was extracted for discussion. A RUC member extracted code 66984 on the basis that the IWPUT of 0.211 was high. The RUC member stated that the amount of intra-service time has gone down dramatically and the technique and complications associated with the procedure seem to have gone down. The RUC member was concerned with the significant reduction in time without a commensurate reduction in work and therefore wanted the full RUC to review code 66984.

The workgroup chair and specialty society indicated that the workgroup was aware of the high IWPUT, however accepted it because this code is a high

intensity procedure from start to finish. **The RUC accepted the workgroup work RVU recommendation of 9.78 for CPT code 66984.**

After the RUC resolved issues surrounding the extracted codes, the full report and consent calendar were adopted. The final RUC recommendations are attached to these minutes.

XIII. Other

Doctor Rich reiterated that all the information discussed at this Five-Year Review is confidential. Doctor Rich discussed new business issues. These issues include:

Research Subcommittee

- Review the survey instrument and summary of recommendation form (Feb 2006)
- Review specific guidelines for new and revised codes on how we evaluate the validity of new data sources (April 2006)
- Review the use of multiple E/M codes performed on the same day in the global period (Feb 2006)
- Define the use of mini-surveys with low volume codes (April 2006)

Administrative Subcommittee

- Review and clarify the conflict of interest statement policy (Feb 2006)

The meeting adjourned on Sunday, October 2, 2005 at noon.

AMA/Specialty Society RVS Update Committee
RUC HCPAC Review Board Meeting
September 29, 2005

Members Present:

Richard Whitten, MD, Chair	Emily H. Hill, PA-C
Mary Foto, OTR, Co-Chair	Bernard Pfeifer, MD
Katherine Bradley, PhD, RN	Christopher Quinn, OD
Jonathan Cooperman, PT	Lloyd Smith, DPM
Robert Fifer, PhD	Doris Tomer, LCSW
James Georgoulakis, PhD	Arthur Traugott, MD
Anthony Hamm, DC	Jane White, PhD, RD, FADA

I. CMS Update

Edith Hambrick, MD, provided a CMS update and indicated that the comment period for the Hospital Outpatient Prospective Payment System closed on September 16, 2005 and that the comment period for the Medicare Physician Fee Schedule would close on September 30, 2005. Doctor Hambrick also informed the HCPAC that Congress is discussing legislation regarding a pay-for-performance system, therefore CMS is investigating this methodology of physician payment. Doctor Hambrick informed the HCPAC that the Medicare drug program under the MMA is scheduled to go into effect on January 1, 2006.

II. Timed Codes

The HCPAC requested clarification from CMS for reporting 15-minute timed codes. AMA staff indicated that in the *CPT Assistant* December 2003 issue, CPT has indicated how one could appropriately code timed codes. For example, if a healthcare professional is performing a procedure for 25 minutes he/she could report the 15-minute timed code twice. If a healthcare professional is performing a procedure for 17 minutes, then he/she should report the 15-minute timed code once. Coding should not be determined just based on the number of minutes spent per body part but rather is limited by the total aggregate time. Doctor Hambrick indicated that she will investigate what CMS's policy is on this issue.

III. PLI Discussion

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

- Clinical Psychologist
- Licensed Clinical Social Worker

- Occupational Therapist
- Psychologist
- Optician
- Optometry
- Chiropractic
- Physical Therapist

At the April 2005 meeting, the HCPAC professions indicated that they would make their best effort to gather information on the collection of PLI premium data and submit it to the HCPAC. The professions indicated above, except opticians/optometry submitted PLI premium data to the HCPAC. Subsequently, at this meeting the dieticians also shared their PLI premium data. **The HCPAC believed that the yearly average PLI premium data per profession is accurate and will submit the data to CMS.**

Specialty Society	Average Yearly Premium	Yearly Premium Range
American Chiropractic Association	$1,870 (in 2005)	$4,000 - $6,000 (New York averages $4,000 and Florida $6,000)
American Occupational Therapy Association		$250 - $1,000 (in 2004/2005)
American Psychological Association	$1,500	
American Physical Therapy Association	$1,100 (2005) $1,500 (projected for 2006)	
American Speech-Language-Hearing Association	$700 (Typical private practice with hearing aid dispensing capabilities)	$62 (Individual) $167 (Group)
National Association of Social Workers	$500	
American Optometric Association	AOA does not have current premium PLI data. AOA does not agree with CMS' crosswalk to the non-surgical risk factor of 1.00.	
American Dietetic Association		$118-$144 (hospital facility) $900 (small practice)

IV. HCPAC Five-Year Review Recommendations

CMS requested that the RUC HCPAC Review Board review six podiatric codes. CMS selected codes 10060 *Drainage of skin abscess*, 11040 *Debride skin, partial*, 11041 *Debride skin, full*, 11042 *Debride skin/tissue*, 11730 *Removal of nail plate* and 29580 *Application of paste boot* to be reviewed because these procedures have never been reviewed by the RUC HCPAC (that is, Harvard RVUs are still being used, or there is no information). The HCPAC agreed with the American Podiatric Medical Association (APMA) that there was compelling evidence due to a flawed methodology used in the previous Harvard valuation and that these codes have never been reviewed by the HCPAC.

The HCPAC agreed with the specialty society and recommends to (1) adopt the recommended increase in the work RVU for code 10060. Although the current work RVU = 1.17, the HCPAC recommends the median work RVU of 1.50 for code 10060 *Drainage of skin abscess*. The HCPAC recommends the modified physician time of 7 minutes for pre-evaluation, 2 minutes pre-positioning, 8 minutes pre-scrub, dress and wait time, 15 minutes intra-service, 10 minutes immediate post-service and one 99212 office visit.

The HCPAC did not agree with the specialty society and (4) suggested a new work RVU for code 11040. Although the current work RVU=0.50, the HCPAC recommends the 25th percentile work RVU of 0.55 for code 11040 *Debride skin, partial*. The HCPAC recommends the survey physician time of 5 minutes for pre-evaluation, 1 minute pre-positioning, 1 minute pre-scrub, dress and wait time, 10 minutes intra-service and 7 minutes immediate post-service time.

The HCPAC agreed with the specialty society and recommends to (3) adopt the recommended decrease in the work RVU for code 11041. Although the current work RVU=0.82, the HCPAC recommends the median work RVU of 0.80 for code 11041 *Debride skin, full*. The HCPAC recommends the modified physician time of 7 minutes for pre-evaluation, 1 minute pre-positioning, 1 minute pre-scrub, dress and wait time, 12 minutes intra-service, and 7 minutes immediate post-service time.

The HCPAC did not agree with the specialty society and recommends to (2) maintain the current work RVU of 1.12 for code 11042 *Debride skin/tissue*. The HCPAC recommends the modified physician time of 9 minutes for pre-evaluation, 1 minute pre-positioning, 1 minute pre-scrub, dress and wait time, 15 minutes intra-service and 10 minutes immediate post-service time.

The HCPAC agreed with the specialty society and recommends to (3) adopt the recommended decrease in the work RVU for code 11730. Although the current work RVU=1.13, the HCPAC recommends the median work RVU of 1.10 for code 11730 *Removal of nail plate*. The HCPAC recommends the survey physician time of 5 minutes for pre-evaluation, 2 minutes pre-positioning, 8 minutes pre-scrub, dress and wait time, 12 minutes intra-service and 10 minutes immediate post-service time.

The HCPAC agreed with the specialty society and recommends to (1) adopt the recommended increase in the work RVU for code 29850. Although the current work RVU=0.57, the HCPAC recommends the median work RVU of 0.60 for code 29850 *Application of paste boot*. The HCPAC recommends the modified physician time of 5 minutes for pre-evaluation, 2 minutes pre-positioning, 1 minute pre-scrub, dress and wait time, 12 minutes intra-service, and 7 minutes immediate post-service time.

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
00797	Anesth, surgery for obesity	8,521	4	N/A	1	30			185	30													245	8.00	11.00
11100	Biopsy, skin lesion	1,981,129	1	0	2	5			12	5													22	0.81	0.81
11400	Exc tr-ext b9+marg 0.5 < cm	58,652	1	10	2	5			10	5									1				35	0.85	0.85
11401	Exc tr-ext b9+marg 0.6-1 cm	103,548	1	10	2	10			20	5									1				50	1.23	1.23
11402	Exc tr-ext b9+marg 1.1-2 cm	123,031	1	10	4	10			25	5									1				55	1.51	1.40
11403	Exc tr-ext b9+marg 2.1-3 cm	58,319	1	10	2	10	5	5	30	10									1				75	1.79	1.79
11404	Exc tr-ext b9+marg 3.1-4 cm	23,393	1	10	2	10	5	5	40	10									1				85	2.06	2.06
11406	Exc tr-ext b9+marg > 4.0 cm	23,256	1	10	4	10	5	5	60	10										1			113	2.76	3.20
11420	Exc h-f-nk-sp b9+marg 0.5 <	37,395	1	10	2	5			10	5									1				35	0.98	0.98
11421	Exc h-f-nk-sp b9+marg 0.6-1	49,725	1	10	2	10			20	5									1				50	1.42	1.42
11422	Exc h-f-nk-sp b9+marg 1.1-2	51,753	1	10	2	10			25	5									1				55	1.63	1.63
11423	Exc h-f-nk-sp b9+marg 2.1-3	22,012	1	10	2	10	5	5	30	10									1				75	2.01	2.01
11424	Exc h-f-nk-sp b9+marg 3.1-4	7,718	1	10	2	10	5	5	40	10									1				85	2.43	2.43
11426	Exc h-f-nk-sp b9+marg > 4 cm	5,430	1	10	2	10	5	5	60	10										1			113	3.77	3.77
11440	Exc face-mm b9+marg 0.5 < cm	71,485	1	10	4	5			10	5									1				35	1.06	1.00
11441	Exc face-mm b9+marg 0.6-1 cm	79,679	1	10	2	10			20	5									1				50	1.48	1.48
11442	Exc face-mm b9+marg 1.1-2 cm	61,434	1	10	2	10			25	5									1				55	1.72	1.72
11443	Exc face-mm b9+marg 2.1-3 cm	18,269	1	10	2	10	5	5	30	10									1				75	2.29	2.29
11444	Exc face-mm b9+marg 3.1-4 cm	5,200	1	10	2	10	5	5	40	10									1				85	3.14	3.14
11446	Exc face-mm b9+marg > 4 cm	2,738	1	10	2	10	5	5	60	10										1			113	4.48	4.48
11600	Exc tr-ext mlg+marg 0.5 < cm	9,023	1	10	2	10			10	5										1			48	1.31	1.31
11601	Exc tr-ext mlg+marg 0.6-1 cm	39,378	1	10	4	15			20	5										1			63	1.80	1.75
11602	Exc tr-ext mlg+marg 1.1-2 cm	121,520	1	10	2	15			25	5										1			68	1.95	1.95
11603	Exc tr-ext mlg+marg 2.1-3 cm	61,629	1	10	4	20	5	5	30	10										1			93	2.19	2.50
11604	Exc tr-ext mlg+marg 3.1-4 cm	24,581	1	10	4	20	5	5	40	10										1			103	2.40	2.85
11606	Exc tr-ext mlg+marg > 4 cm	22,555	1	10	4	20	5	5	90	10										1			153	3.42	4.70
11620	Exc h-f-nk-sp mlg+marg 0.5 <	4,813	1	10	4	10			10	5										1			48	1.19	1.32
11621	Exc h-f-nk-sp mlg+marg 0.6-1	21,521	1	10	2	15			20	5										1			63	1.76	1.76
11622	Exc h-f-nk-sp mlg+marg 1.1-2	53,607	1	10	2	15			25	5										1			68	2.09	2.09
11623	Exc h-f-nk-sp mlg+marg 2.1-3	23,235	1	10	4	20	5	5	30	10										1			93	2.61	2.79
11624	Exc h-f-nk-sp mlg+marg 3.1-4	8,418	1	10	4	20	5	5	40	10										1			103	3.06	3.30
11626	Exc h-f-nk-sp mlg+mar > 4 cm	7,033	1	10	2	20	5	5	60	10										1			123	4.29	4.29
11640	Exc face-mm malig+marg 0.5 <	26,146	1	10	2	10			10	5										1			48	1.35	1.35
11641	Exc face-mm malig+marg 0.6-1	93,199	1	10	4	15			20	5										1			63	2.16	1.85
11642	Exc face-mm malig+marg 1.1-2	152,434	1	10	4	15			25	5										1			68	2.59	2.30
11643	Exc face-mm malig+marg 2.1-3	50,764	1	10	2	20	5	5	30	10										1			93	3.10	3.10
11644	Exc face-mm malig+marg 3.1-4	16,480	1	10	2	20	5	5	45	10										1			108	4.02	4.02
11646	Exc face-mm mlg+marg > 4 cm	10,275	1	10	2	20	5	5	65	10										1			128	5.94	5.94
12052	Layer closure of wound(s)	73,449	1	10	2	5			28	10									2				73	2.77	2.77
13121	Repair of wound or lesion	47,763	1	10	2	10			60	15									2				115	4.32	4.32
14040	Skin tissue rearrangement	75,938	1	90	2	15	10	5	90	25									2	2			221	7.86	7.86
14060	Skin tissue rearrangement	89,343	1	90	2	15	10	5	60	15									2	2			181	8.49	8.49
15100	Skin split graft	21,432	1	90	2	45	10	10	60	20			1			1			2	2			276	9.04	9.04
15240	Skin full graft	11,260	1	90	2	45	10	10	60	20						1			2	4			285	9.03	9.03
15734	Muscle-skin graft, trunk	12,638	1	90	2	30	15	15	163	30			1	1	1	1			2	2	1		493	17.76	17.76
17003	Destroy lesions, 2-14	14,967,497	1	ZZZ	4				2														2	0.15	0.07
17262	Destruction of skin lesions	155,455	1	10	2	5	3		15	5									1				43	1.58	1.58
17281	Destruction of skin lesions	149,754	1	10	2	5	3		14	5									1				42	1.72	1.72

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
19180	Removal of breast	15,560	7	90	4	30	15	15	90	20			1			1				2	1		309	8.79	14.67
20600	Drain/inject, joint/bursa	363,057	2	0	2	10	2	2	5	5													24	0.66	0.66
20610	Drain/inject, joint/bursa	4,532,254	2	0	2	7			15	7													29	0.79	0.79
20680	Removal of support implant	50,794	2	90	4	35	15	15	50	15						0.5			2				178	3.34	5.86
21145	Reconstruct midface, lefort	12	1	90	4	43			202	64			1.5			1				6			511.5	19.91	21.84
21146	Reconstruct midface, lefort	2	1	90	4	46			227	67			2			1				6.5			563.5	20.68	22.55
21147	Reconstruct midface, lefort	3	1	90	4	46			252	67	1.5		2.5			1				6.5			692.5	21.74	23.32
21395	Treat eye socket fracture	15	1	90	4	30	15	15	120	30			1	1		1			1	1			333	12.66	13.88
22520	Percut vertebroplasty thor	13,992	3	10	2	30	15	15	45	30						0.5				1			176	8.90	8.90
22554	Neck spine fusion	24,477	3	90	3	60	20	15	90	30				1		1				3			350	18.59	16.40
22612	Lumbar spine fusion	43,306	3	90	4	60	20	15	150	30			1	2		1				3			459	20.97	22.00
22840	Insert spine fixation device	15,975	3	ZZZ	2				60														60	12.52	12.52
24363	Replace elbow joint	1,013	2	90	4	50	17.5	15	150	30			2	1		1			1	3			450.5	18.46	21.07
24430	Repair of humerus	641	2	90	4	30	18	15	102	15			2			1			1	3			338	12.79	14.00
25447	Repair wrist joint(s)	8,991	2	90	2	20	15	10	100	20						0.5			3	2			274	10.35	10.35
26055	Incise finger tendon sheath	59,370	2	90	2	20	15	5	20	20						0.5			2	1			151	2.69	2.69
26160	Remove tendon sheath lesion	12,971	2	90	2	20	15	5	20	20						0.5			2	1			151	3.15	3.15
26600	Treat metacarpal fracture	16,336	2	90	1	7	2	0	15	5									4				89	1.96	2.40
26951	Amputation of finger/thumb	7,509	2	90	4	20	15	5	30	20						0.5			3	2			199	4.58	5.25
27130	Total hip arthroplasty	106,878	2	90	2	60	15	15	135	30			3	1		1			1	3			462	20.09	20.09
27236	Treat thigh fracture	84,217	2	90	2	60	15	15	90	30			3	2		1			1	3			447	15.58	15.58
27447	Total knee arthroplasty	246,836	2	90	2	45	15	15	124	30			3	1		1			1	2	1		451	21.45	21.45
27465	Shortening of thigh bone	26	2	90	1	33	20	13	120	23			3			1			2	2			378	13.85	17.50
27470	Repair of thigh	612	2	90	2	30	10	15	120	20			2	1		1			4	1			382	16.05	16.05
27709	Incision of tibia & fibula	161	2	90	4	40	18	10	108	15			2			1			2	2			341	9.94	16.50
27880	Amputation of lower leg	20,589	7	90	1	30	15	15	80	20			5	1		1			1	2			382	11.83	13.75
28805	Amputation thru metatarsal	7,137	7	90	1	30	15	15	60	20			6			1			2	2			366	8.38	11.25
29075	Application of forearm cast	70,341	2	0	2	10	2	3	10														25	0.77	0.77
30520	Repair of nasal septum	19,687	8	90	4	13.5	10	15	60	15						0.5			2	2			207.5	5.69	6.27
31225	Removal of upper jaw	802	8	90	1	45	15	20	180	30			1	2	1	1.0			1	3	1		568	19.20	24.00
31230	Removal of upper jaw	71	8	90	1	60	15	20	225	30			2	2	1	1.0			1	3	1		647	21.91	28.00
31360	Removal of larynx	668	8	90	1	60	15	20	200	35			3	3	1	1.0			1	3	2		714	17.05	28.00
31365	Removal of larynx	513	8	90	1	60	15	20	300	40			4	3	1	1.0			1	3	2		838	24.12	37.00
31367	Partial removal of larynx	74	8	90	4	60	15	20	180	35			2	3	1	1.0			1	3	2		675	21.83	27.36
31368	Partial removal of larynx	61	8	90	1	60	15	20	285	40			3	3	1	1.0			1	3	2		804	27.05	36.00
31370	Partial removal of larynx	69	8	90	1	60	15	20	180	35			2	3	1	1.0			1	3	2		675	21.35	25.00
31375	Partial removal of larynx	48	8	90	1	60	15	20	150	35			2	3	1	1.0			1	3	2		645	20.18	25.00
31380	Partial removal of larynx	28	8	90	1	60	15	20	160	35			2	3	1	1.0			1	3	2		655	20.18	25.00
31382	Partial removal of larynx	55	8	90	1	60	15	20	180	35			2	3	1	1.0			1	3	2		675	20.49	28.00
31390	Removal of larynx & pharynx	90	8	90	1	60	15	20	360	40			3	3	2	1.0			1	3	2		920	27.49	40.00
31395	Reconstruct larynx & pharynx	71	8	90	1	60	15	20	400	40			4	3	2	1.0			1	3	2		979	31.04	44.00
31575	Diagnostic laryngoscopy	500,946	8	0	2	5	5	5	8	5													28	1.10	1.10
31579	Diagnostic laryngoscopy	24,241	8	0	2	10	5	0	15	15													45	2.26	2.26
31622	Dx bronchoscope/wash	100,186	4	0	2	10	5	5	30	15													65	2.78	2.78
32141	Remove/treat lung lesions	634	6	90	4	60	15	20	116	40			1	4	3	1			1	1			587	13.98	23.90
32442	Sleeve pneumonectomy	15	6	90	4	60	15	20	286	60			1	4	6	1				2			908	26.20	51.45
32445	Removal of lung	99	6	90	4	60	15	20	310	40	1		1	4	6	1			1	1	2		1043	25.05	57.74
32484	Segmentectomy	1,320	6	90	4	60	15	20	139	40			1	2	2	1			1	1			509	20.66	23.25

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
32486	Sleeve lobectomy	120	6	90	4	60	15	20	240	40			1	3	4	1			1	1			722	23.88	39.44
32488	Completion pneumonectomy	179	6	90	4	60	15	20	194	40	1		1	2	4	1			1	1	1		747	25.67	38.95
32540	Removal of lung lesion	157	6	90	4	60	15	20	120	40			1	5	3	1			1	2			644	14.62	26.42
32651	Thoracoscopy, surgical	1,138	6	90	4	60	15	20	70	40			1	5		1			1	1			448	12.89	16.64
32652	Thoracoscopy, surgical	1,045	6	90	4	60	15	20	160	40			1	3	2	1			1	2			583	18.63	26.35
32653	Thoracoscopy, surgical	604	6	90	4	60	15	20	77	40			2	4		1			1	1			444	12.85	16.24
32654	Thoracoscopy, surgical	92	6	90	4	10	12	15	71	40			1	4	2	1			1	1			443	12.42	17.73
32655	Thoracoscopy, surgical	563	6	90	4	60	15	20	73	40			1	3		1			1	1			391	13.08	14.69
32657	Thoracoscopy, surgical	6,520	6	90	4	60	15	20	60	40				2		1			1	1			329	13.63	11.90
32662	Thoracoscopy, surgical	273	6	90	4	60	15	20	98	40				1		1			1	1			337	16.42	14.29
32663	Thoracoscopy, surgical	1,281	6	90	4	60	15	20	145	40			1	2	1	1			1	1			474	18.44	23.00
32665	Thoracoscopy, surgical	35	6	90	4	60	15	20	105	40			1	3	1	1			1	1			464	15.52	19.56
32815	Close bronchial fistula	174	6	90	4	60	15	20	155	40	1		1	7	6	1			1	1	2		978	23.12	42.94
33140	Heart revascularize (tmr)	129	6	90	4	60	15	20	113	40	1		1	1	3	1					1		557	19.97	25.49
33141	Heart tmr w/other procedure	1,673	6	ZZZ	3				19		0.11				0								30.03	4.83	2.43
33208	Insertion of heart pacemaker	131,714	4	90	2	15	15	15	60	30													135	8.12	8.12
33300	Repair of heart wound	267	6	90	4	10	12	15	144	40	3	1	1	2	4	1					1		759	17.89	40.03
33305	Repair of heart wound	238	6	90	4	10	12	15	296	40	6	2	1	2	4	1					1		1132	21.41	70.21
33400	Repair of aortic valve	293	6	90	4	60	15	20	211	40	1		1	1	3	1				1	1		678	28.46	38.33
33405	Replacement of aortic valve	30,407	6	90	4	60	15	20	198	40	1		1	2	3	1				1	1		695	34.95	37.82
33406	Replacement of aortic valve	621	6	90	4	60	15	20	282	40	1		1	2	3	1				1	1		779	37.44	49.18
33410	Replacement of aortic valve	1,696	6	90	4	60	15	20	229	40	1		1	2	3	1				1	1		726	32.41	42.91
33411	Replacement of aortic valve	834	6	90	4	60	15	20	283	40	2		1	4	4	1				1	1		944	36.20	56.91
33413	Replacement of aortic valve	9	6	90	4	60	15	20	297	40	2		1	1	3	1				1	1		827	43.43	56.19
33414	Repair of aortic valve	62	6	90	4	60	15	15	240	60	1		1	1	3	1					1		699	30.30	36.52
33415	Revision, subvalvular tissue	100	6	90	4	60	15	20	186	40	1		1	2	2	1					1		619	27.11	34.58
33416	Revise ventricle muscle	536	6	90	4	60	18	15	205	60	1		2	1	1	1				1	1		627	30.30	34.25
33425	Repair of mitral valve	696	6	90	4	60	15	20	254	40	1		1	2	4	1				1	1		792	26.96	45.97
33426	Repair of mitral valve	7,622	6	90	4	60	15	20	205	40	1		1	2	3	1				1	1		702	32.95	39.78
33427	Repair of mitral valve	2,815	6	90	4	60	15	20	221	40	1		1	2	2	1				1	1		677	39.94	41.82
33430	Replacement of mitral valve	11,268	6	90	4	60	15	20	223	40	2		1	2	3		1			2	1		815	33.45	46.45
33460	Revision of tricuspid valve	66	6	90	4	60	15	20	164	40	1		1	3	5	1					1		750	23.56	40.19
33463	Valvuloplasty, tricuspid	885	6	90	4	60	15	20	231	40	2		1	7	4	1				1	1		982	25.58	50.93
33464	Valvuloplasty, tricuspid	2,446	6	90	4	60	15	20	205	40	1		1	3	4	1				1	1		773	27.29	40.30
33465	Replace tricuspid valve	337	6	90	4	60	15	20	211	40	2		1	5	3	1				1	1		861	28.75	45.72
33474	Revision of pulmonary valve	14	6	90	4	60	15	20	222	40	1		1	2	2	1				1	1		678	23.01	36.39
33475	Replacement, pulmonary valve	60	6	90	4	60	15	20	234	40	1		1	2	2	1				1	1		690	32.95	39.39
33505	Repair artery w/tunnel	5	6	90	1	40	12	20	200	40	1		9		1	1				1			646	26.80	36.00
33510	CABG, vein, single	7,775	6	90	4	60	15	20	154	40	1		1	2	3	1			1		1		643	28.96	31.75
33511	CABG, vein, two	8,165	6	90	4	60	15	20	186	40	1		1	2	3	1			1		1		675	29.96	35.22
33512	CABG, vein, three	8,168	6	90	4	60	15	20	213	40	1		1	2	4	1			1		1		743	31.75	40.26
33513	CABG, vein, four	3,873	6	90	4	60	15	20	231	40	1		1	2	4	1			1		1		761	31.95	41.65
33514	CABG, vein, five	1,103	6	90	4	60	15	20	248	40	1		1	2	4	1			1		1		778	32.70	44.36
33516	Cabg, vein, six or more	233	6	90	4	60	15	20	264	40	1		1	2	4	1			1		1		794	34.95	46.04
33517	CABG, artery-vein, single	20,588	6	ZZZ	1				23		0.2				0								47.9	2.57	3.36
33518	CABG, artery-vein, two	46,283	6	ZZZ	1				50		0.36				1								100.6	4.84	7.41
33519	CABG, artery-vein, three	36,938	6	ZZZ	1				70		0.4				1								126.4	7.11	9.91
33521	CABG, artery-vein, four	12,106	6	ZZZ	1				88		0.38				1								144.3	9.39	12.01

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33522	CABG, artery-vein, five	2,129	6	ZZZ	1				102		0.32				1								159.5	11.65	13.53
33523	Cabg, art-vein, six or more	399	6	ZZZ	1				110		0.4				1								176.2	13.93	15.39
33530	Coronary artery, bypass/reop	15,685	6	ZZZ	1				70		0.26				0								104.4	5.85	9.78
33533	CABG, arterial, single	113,651	6	90	4	60	15	20	151	40	1		1	1	3	1			1		1		610	29.96	30.85
33534	CABG, arterial, two	11,647	6	90	4	60	15	20	193	40	1		1	1	3	1			1		1		652	32.15	36.98
33535	CABG, arterial, three	2,937	6	90	4	60	15	20	231	40	1		1	1	3	1			1		1		690	34.45	41.85
33536	Cabg, arterial, four or more	1,119	6	90	4	60	15	20	259	40	1		1	1	3	1			1		1		718	37.44	45.53
33542	Removal of heart lesion	1,167	6	90	4	60	15	20	207	40	2		1	2	3	1				1	1		767	28.81	44.20
33545	Repair of heart damage	159	6	90	4	60	15	20	236	40	2	1	1	1	4		1			1	1		848	36.72	52.49
33641	Repair heart septum defect	2,330	6	90	4	60	15	20	164	40	1		1	1	1	1					1		526	21.36	27.71
33665	Repair of heart defects	2	6	90	1	60	15	15	200	60	1		1	1	1	1					1		577	28.56	32.98
33684	Repair heart septum defect	3	6	90	1	63	15	15	200	60	1		1	1	1	1					1		580	29.61	32.50
33688	Repair heart septum defect		6	90	4	60	15	15	235	40	1		1	1	1	1					1		592	30.57	32.88
33771	Repair great vessels defect	1	6	90	4	60	15	15	260	60	1		4	1	1	1				1			679	34.60	38.50
33779	Repair great vessels defect		6	90	4	60	15	15	280	40	1		4	1	1	1					1		694	36.16	41.00
33781	Repair great vessels defect	1	6	90	4	60	12	15	280	40	1		6	2		1				1			703	36.40	41.00
33860	Ascending aortic graft	2,862	6	90	4	45	15	20	305	40	2		1	2	3	1				1	1		850	37.94	55.45
33863	Ascending aortic graft	1,815	6	90	4	60	15	20	287	40	2		1	2	3	1					1		824	44.93	55.10
33877	Thoracoabdominal graft	920	7	90	1	50	45	15	324	60	3		1	2	3		1			2	1		1014	42.54	64.04
33945	Transplantation of heart	520	6	90	4	167	15	90	325	85	3	1	1	6	5		1			3	2	1	1556	42.04	80.84
34001	Removal of artery clot	208	7	90	1	30	15	15	90	30				3		1				2			352	12.89	16.25
34201	Removal of artery clot	7,971	7	90	4	30	15	15	128	30			2	2		1				2			398	10.01	18.31
34471	Removal of vein clot	51	7	90	1	30	15	15	180	20			3	1		1			2	1			436	10.16	20.00
35081	Repair defect of artery	7,765	7	90	4	60	15	15	210	30	1		2	3		1			1	1	1		633	27.97	31.00
35102	Repair defect of artery	5,321	7	90	4	60	15	15	265	30	1		2	3		1			1	1	1		688	30.71	36.28
35216	Repair blood vessel lesion	286	7	90	4	30	15	15	180	60	1		3	3		1		1		1	1		614	18.72	34.00
35506	Artery bypass graft	83	7	90	1	30	15	15	165	28			1	1	1	1				2			425	19.64	23.75
35508	Artery bypass graft	20	7	90	1	30	15	15	170	30			1	1		1				2			391	18.62	25.00
35515	Artery bypass graft	6	7	90	1	30	15	15	180	30			1	1		1				2			401	18.62	25.00
35516	Artery bypass graft	35	7	90	1	30	15	15	180	20			2	1		1				2			410	16.30	23.00
35556	Artery bypass graft	6,905	7	90	4	30	25	15	251	30			2	1	1	1			1	2			557	21.73	27.25
35566	Artery bypass graft	6,573	7	90	4	30	25	15	306	30			3	2	1		1		1	2			670	26.88	32.00
35583	Vein bypass graft	3,004	7	90	4	30	25	15	253	30			2	1	1	1			1	2			559	22.34	26.00
35585	Vein bypass graft	4,203	7	90	4	30	25	15	305	30			3	2	1		1		1	2			669	28.35	32.00
35606	Artery bypass graft	755	7	90	1	30	15	15	145	30				1	1	1				2			388	18.68	21.00
35616	Artery bypass graft	72	7	90	4	30	15	15	140	30			1	1		1			1	1			353	15.68	21.00
35820	Explore chest vessels	7,333	6	90	4	30	10	5	136	40	1		1	2	6	1					1		683	12.86	32.24
38100	Removal of spleen, total	4,133	7	90	4	30	15	15	120	30			3	1	1	1			1	1			412	14.48	18.00
38101	Removal of spleen, partial	45	7	90	1	30	15	15	120	30			3	1	1	1			1	1			412	15.29	18.00
38115	Repair of ruptured spleen	245	7	90	1	30	15	15	120	40			3	2	1	1			1	1			452	15.80	20.00
38700	Removal of lymph nodes, neck	918	8	90	1	30	15	15	90	30			1			1.0			1	2			296	8.23	12.00
38720	Removal of lymph nodes, neck	960	8	90	1	45	15	15	150	30			2	1		1.0				3	1		466	13.59	20.00
38724	Removal of lymph nodes, neck	4,620	8	90	1	45	15	15	180	30			2	1		1.0				3	1		496	14.52	22.00
39220	Removal chest lesion	522	6	90	4	60	15	20	124	40			1	2		1			1	1			412	17.39	18.40
39400	Visualization of chest	14,114	6	10	1	35	15	20	45	25			1			1				1			218	5.60	7.61
41100	Biopsy of tongue	6,785	8	10	2	10	10	5	15	10									1				65	1.63	1.63
41120	Partial removal of tongue	1,537	8	90	2	30	15	15	60	30						0.5				3	1		275	9.76	9.76
41130	Partial removal of tongue	267	8	90	1	45	15	20	90	30			3			1.0				3	1		400	11.13	14.00

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41135	Tongue and neck surgery	336	8	90	1	60	15	20	210	30			2	2	1	1.0			1	4	1		655	23.06	27.00
41140	Removal of tongue	23	8	90	2	60	15	20	155	40			3	3	1	1.0			1	3	2		674	25.46	25.46
41145	Tongue removal, neck surgery	51	8	90	1	60	15	20	300	40			5	3	1	1.0			1	3	2		857	30.01	34.00
41150	Tongue, mouth, jaw surgery	249	8	90	1	60	15	20	180	40			3	2	1	1.0			1	3	2		669	23.01	26.50
41153	Tongue, mouth, neck surgery	163	8	90	1	60	15	20	270	40			3	3	1	1.0			1	4	1		774	23.73	34.00
41155	Tongue, jaw, & neck surgery	548	8	90	1	60	15	20	320	40			4	3	2	1.0			1	3	2		899	27.68	40.00
42120	Remove palate/lesion	590	8	90	1	30	15	15	80	30			1			1.0			2	2			301	6.16	11.00
42842	Extensive surgery of throat	265	8	90	1	30	15	15	80	30			1			1.0			1	2	1		324	8.75	11.00
42844	Extensive surgery of throat	85	8	90	1	45	15	15	120	30			2	1		1.0			1	2	1		428	14.29	16.10
42845	Extensive surgery of throat	54	8	90	1	60	15	20	240	40			4	3	2	1.0			1	2	1		758	24.25	32.00
42890	Partial removal of pharynx	227	8	90	1	45	15	20	120	30			3	2		1.0			1	2	1		482	12.92	17.00
42892	Revision of pharyngeal walls	133	8	90	1	45	15	20	170	35			3	2	1	1.0			1	3	1		601	15.81	23.09
42894	Revision of pharyngeal walls	100	8	90	1	60	15	20	240	40			3	4	1	1.0			1	4	1		774	22.85	30.00
43108	Removal of esophagus	27	6	90	4	60	15	20	461	40	1		1	6	5		1		1	2	1		1207	34.14	76.55
43113	Removal of esophagus	11	6	90	4	60	15	20	391	40	2		1	6	5		1		1	2	1		1200	35.22	73.23
43116	Partial removal of esophagus	12	6	90	4	60	15	20	561	40	1		1	6	4		1		1	2	1		1266	31.17	87.16
43118	Partial removal of esophagus	20	6	90	4	60	15	20	327	40	1		1	5	5		1		1	2	1		1043	33.15	61.08
43121	Partial removal of esophagus	60	6	90	4	60	15	20	240	40	1		1	3	4		1		1	2	1		855	29.15	46.59
43123	Partial removal of esophagus	26	6	90	4	60	15	20	442	40	1		1	8	5		1		1	2	1		1248	33.15	76.14
43124	Removal of esophagus	50	6	90	4	60	15	20	243	40	3		1	7	6		1		1	3	1		1209	27.28	60.61
43135	Removal of esophagus pouch	132	6	90	4	60	15	20	164	40			1	3	1	1			1	1			523	16.08	24.20
43235	Uppr gi endoscopy, diagnosis	510,944	4	0	2	18	5	5	20	15													63	2.39	2.39
43246	Place gastrostomy tube	136,643	4	0	2	35	8	5	38	20													106	4.32	4.32
43620	Removal of stomach	180	7	90	1	30	15	15	200	30	1		3	3	1	1			1	2			638	29.99	31.00
43621	Removal of stomach	767	7	90	4	30	15	15	240	30	1		3	3	2	1			1	2			719	30.68	36.00
43622	Removal of stomach	147	7	90	4	30	15	15	240	30	1		3	3	2	1			1	2			719	32.48	36.50
43632	Removal of stomach, partial	2,910	7	90	4	30	15	15	225	30			4	3	2	1			1	2			660	22.56	32.00
43633	Removal of stomach, partial	1,381	7	90	4	30	15	15	240	30			4	3	2	1			1	2			675	23.07	30.00
43634	Removal of stomach, partial	32	7	90	1	30	15	15	240	30			4	3	2	1			1	2			675	25.08	33.50
43750	Place gastrostomy tube	32,754	4	10	2	16	10	10	30	15			1						1				115	4.48	4.48
43820	Fusion of stomach and bowel	2,938	7	90	4	30	15	15	120	30			3	3	1	1			1	2			495	15.35	20.00
43840	Repair of stomach lesion	5,556	7	90	4	30	15	15	90	30	1		4	2	1	1			1	2			517	15.54	20.00
44120	Removal of small intestine	30,806	7	90	4	30	15	15	134	30			4	3	2	1			1	1			546	16.97	20.11
44130	Bowel to bowel fusion	2,707	7	90	4	30	15	15	131	30			5	1	1	1			1	2			484	14.47	20.87
44140	Partial removal of colon	48,464	7	90	2	30	15	15	150	30			5	1		1			1	2			462	20.97	20.97
44143	Partial removal of colon	17,331	7	90	4	30	15	15	150	30			3	2	2	1			1	1	1		551	22.96	25.00
44150	Removal of colon	5,469	7	90	4	30	15	15	180	30			3	3	1	1			2	1	1		585	23.91	27.50
44151	Removal of colon/ileostomy	99	7	90	4	30	15	15	240	30			5	3	1	1			2	1	1		683	26.84	32.00
44155	Removal of colon/ileostomy	934	7	90	4	30	15	15	240	30			5	3	1	1			2	1	1		683	27.82	31.50
44156	Removal of colon/ileostomy	27	7	90	1	30	15	15	300	30			5	3	1	1			2	1	1		743	30.74	34.50
44602	Suture, small intestine	4,803	7	90	4	30	15	15	90	30	1		3	3	1	1			1	1			505	16.01	22.00
44603	Suture, small intestine	1,687	7	90	1	30	15	15	120	30	1		4	3	1	1			1	2			577	18.63	25.00
45020	Drainage of rectal abscess	637	7	90	1	30	15	15	45	30			1			1			1	2			251	4.71	7.75
45300	Proctosigmoidoscopy dx	57,539	7	0	4	10	5	1	10	10													36	0.38	0.91
45303	Proctosigmoidoscopy dilate	504	7	0	4	20	10	5	20	30													85	0.44	2.22
45305	Proctosigmoidoscopy w/bx	2,219	7	0	4	20	10	5	15	30													80	1.01	2.01
45307	Proctosigmoidoscopy fb	151	7	0	4	20	10	5	20	30													85	0.94	2.22
45308	Proctosigmoidoscopy removal	280	7	0	4	20	10	5	15	30													80	0.83	2.01

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45309	Proctosigmoidoscopy removal	229	7	0	4	20	10	5	20	30													85	2.01	2.22
45315	Proctosigmoidoscopy removal	110	7	0	4	20	10	5	20	30													85	1.40	2.22
45317	Proctosigmoidoscopy bleed	930	7	0	4	10	5	1	15	10													41	1.50	1.08
45320	Proctosigmoidoscopy ablate	207	7	0	4	20	10	5	25	30													90	1.58	2.43
45321	Proctosigmoidoscopy volvul	271	7	0	4	20	10	5	30	30													95	1.17	2.76
45327	Proctosigmoidoscopy w/stent	22	7	0	4	20	10	5	45	30													110	1.65	3.63
45330	Diagnostic sigmoidoscopy	122,925	4	0	2	7			17	8													32	0.96	0.96
45378	Diagnostic colonoscopy	1,143,087	4	0	2	20	5	5	30	15													75	3.69	3.69
46040	Incision of rectal abscess	5,767	7	90	2	30	15	15	30	20						0.5			2	1			181	4.95	4.95
46045	Incision of rectal abscess	338	7	90	1	30	15	15	30	30						1			1	1			194	4.31	5.50
46060	Incision of rectal abscess	1,104	7	90	2	30	15	15	40	20						0.5			1	2			199	5.68	5.68
46270	Removal of anal fistula	1,691	7	90	1	30	15	15	15	20						0.5			2	1			166	3.71	4.50
46275	Removal of anal fistula	1,218	7	90	1	30	15	15	30	20						0.5			2	1			181	4.55	5.00
46280	Removal of anal fistula	1,519	7	90	2	30	15	15	45	20						0.5			2	1			196	5.97	5.97
46285	Removal of anal fistula	130	7	90	1	30	15	15	30	20						0.5			2	1			181	4.08	5.00
46600	Diagnostic anoscopy	95,217	7	0	4	5	2	1	7	5													20	0.50	0.49
46604	Anoscopy and dilation	1,511	7	0	4	10	5	1	15	10													41	1.31	1.08
46606	Anoscopy and biopsy	1,713	7	0	4	20	10	5	10	30													75	0.81	1.76
46608	Anoscopy, remove for body	110	7	0	4	20	10	5	15	30													80	1.51	1.95
46610	Anoscopy, remove lesion	284	7	0	4	20	10	5	15	30													80	1.32	1.95
46611	Anoscopy	176	7	0	4	10	5	1	15	10													41	1.81	1.08
46612	Anoscopy, remove lesions	106	7	0	4	20	10	5	20	30													85	2.34	2.14
46614	Anoscopy, control bleeding	1,737	7	0	4	5	5	1	15	15													41	2.01	1.08
46615	Anoscopy	322	7	0	4	10	5	1	18	10													44	2.68	1.18
47562	Laparoscopic cholecystectomy	119,297	7	90	2	30	15	15	80	25						0.5			1	2			244	11.07	11.07
47600	Removal of gallbladder	29,510	7	90	4	30	15	15	115	30			1	1	1	1			1	2			392	13.56	15.88
47760	Fuse bile ducts and bowel	819	7	90	4	45	15	15	195	45	1		3	2	2	1				2	1		697	25.81	34.75
47765	Fuse liver ducts & bowel	43	7	90	1	45	15	15	290	53	1		4	2	2	1				2	1		819	24.84	48.50
47780	Fuse bile ducts and bowel	1,173	7	90	4	45	15	15	240	40	1		3	2	2	1				2	1		737	26.46	38.75
47785	Fuse bile ducts and bowel	306	7	90	4	45	15	15	360	40	1		4	2	2	1				2	1		876	31.13	52.50
49002	Reopening of abdomen	4,599	7	90	4	30	15	15	75	30			3	2	1	1			1	1			397	10.47	15.75
49010	Exploration behind abdomen	1,646	7	90	4	30	15	15	90	30			3	1		1			1	1			341	12.26	15.00
49505	Prp i/hern init reduc >5 yr	107,403	7	90	2	20	15	15	70	20						0.5			1	1			196	7.59	7.59
50590	Fragmenting of kidney stone	52,828	3	90	2	35	15	13	60	30						0.5			1	2			232	9.08	9.08
51720	Treatment of bladder lesion	208,892	3	0	4	20	2	5	12	10													49	1.96	1.50
51798	Us urine capacity measure	1,174,387	3	XXX	1	5			4														9	0.00	0.38
52000	Cystoscopy	952,641	3	0	4	10	2	5	15	10													42	2.01	2.23
52204	Cystoscopy	39,733	3	0	4	10	2	5	25	12													54	2.37	2.59
52601	Prostatectomy (TURP)	70,777	3	90	4	35	10	15	75	40			2	1		1			1	2			340	12.35	14.00
55700	Biopsy of prostate	233,082	3	0	4	20	5	5	15	20													65	1.57	2.58
57160	Insert pessary/other device	111,204	3	0	2	10	5	5	15	5													40	0.89	0.89
57240	Repair bladder & vagina	14,024	3	90	4	45	5	10	60	30			2	1		1			1	1			292	6.06	10.56
57250	Repair rectum & vagina	9,539	3	90	4	45	5	10	60	30			2	1		1			1	1			292	5.52	10.56
57260	Repair of vagina	17,038	3	90	4	45	5	10	90	30			2	1		1			1	1			322	8.26	13.50
57265	Extensive repair of vagina	6,676	3	90	4	45	5	10	120	30			2	1		1			1	1			352	11.32	15.00
57288	Repair bladder defect	38,242	3	90	2	35	10	15	60	40			1	1		1			1	2			306	13.00	13.00
57500	Biopsy of cervix	9,266	3	0	4	7	1	1	15	5													29	0.97	1.20
58120	Dilation and curettage	19,325	3	10	2	20	5	10	25	27						0.5				1			128	3.27	3.27

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
58150	Total hysterectomy	24,214	3	90	4	45	5	10	120	30			3	1		1				2			379	15.22	15.98
58720	Removal of ovary/tube(s)	8,593	3	90	2	37	5	10	90	30			1	1		1			1	1			295	11.34	11.34
60600	Remove carotid body lesion	119	7	90	1	45	15	15	180	30			1	1		1				2			416	17.90	24.00
60605	Remove carotid body lesion	32	7	90	1	45	15	15	240	36				1	1	1				2			504	20.21	30.50
61154	Pierce skull & remove clot	8,547	3	90	2	60	15	15	60	30			4	2		1				3			421	14.97	14.97
61312	Open skull for drainage	9,350	3	90	1	60	15	15	150	30			6	4	1	1				2			627	24.53	27.00
61537	Removal of brain tissue	115	3	90	1	60	20	20	265	45			4	1		1				2			598	24.96	35.00
61538	Removal of brain tissue	109	3	90	1	60	20	20	330	45			4	1		1				2			663	26.77	38.00
61697	Brain aneurysm repr, complx	781	3	90	4	60	30	15	300	50			5	6	5	1				2	1		1055	50.44	57.31
61698	Brain aneurysm repr, complx	60	3	90	4	60	40	15	360	50			5	6	4	1				2	1		1084	48.34	64.03
61700	Brain aneurysm repr, simple	1,181	3	90	4	60	30	15	240	40			5	3	4	1				2	1		854	50.44	46.01
61702	Inner skull vessel surgery	44	3	90	4	60	40	15	280	50			5	5	5	1				2	1		1015	48.34	54.28
62270	Spinal Fluid Tap, diagnostic	76,191	4	0	4	7			20	5													32	1.13	1.37
63047	Removal of spinal lamina	75,647	3	90	3	60	20	15	90	30				1		1				3			350	14.59	14.08
63048	Remove spinal lamina add-on	118,656	3	ZZZ	4				45														45	3.26	3.55
63075	Neck spine disk surgery	19,930	3	90	3	60	20	15	90	30				1		1			1	2			342	19.38	18.58
64702	Revise finger/toe nerve	768	2	90	4	20	15	10	50	20						0.5			2	2			209	4.22	5.52
64721	Carpal tunnel surgery	114,443	2	90	2	20	15	10	25	20						0.5			1	2			169	4.28	4.28
65426	Removal of eye lesion	4,706	8	90	4	5	5	10	47.5	12						0.5			4				157.5	5.24	5.85
65850	Incision of eye	338	8	90	4	15	10	12.5	60	17.5						1.0			5				226	10.50	11.14
66761	Revision of iris	85,708	8	90	2	10	5	1	10	10										3			105	4.06	4.06
66821	After cataract laser surgery	675,728	8	90	4	15			11	10										2			82	2.35	2.78
66984	Cataract surg w/iol, 1 stage	1,802,958	8	90	4	10	5	10	30	10						0.5			2	2			159	10.21	9.78
67221	Ocular photodynamic ther	126,894	8	0	4	10	0	0	15	5													30	4.00	3.45
67414	Explr/decompress eye socket	318	8	90	1	15	10	15	120	30				1		1.0			1	1	1		332	11.11	16.82
67445	Explr/decompress eye socket	222	8	90	1	15	15	15	120	30				1		1.0			1	1	1		337	14.40	18.00
67500	Inject/treat eye socket	16,121	8	0	1	5	5	5	5	5													25	0.79	1.44
67505	Inject/treat eye socket	1,210	8	0	1	10	5	5	10	5													35	0.82	1.27
67515	Inject/treat eye socket	35,076	8	0	1	6	5	0	5	5													21	0.61	1.40
67820	Revise eyelashes	285,124	8	0	3	5	2	1	5	2													15	0.89	0.71
67840	Remove eyelid lesion	49,843	8	10	2	5	5	5	15	10									1				55	2.04	2.04
67904	Repair eyelid defect	56,300	8	90	1	10	10	15	45	15						0.5			3	1			181	6.25	7.50
67911	Revise eyelid defect	2,790	8	90	1	10	10	15	50	15						0.5			4				178	5.26	7.30
67966	Revision of eyelid	5,926	8	90	1	10	10	15	60	15						0.5			3	1			196	6.56	8.50
68840	Explore/irrigate tear ducts	37,656	8	10	2	5	3	0	10	5									1				38	1.25	1.25
69210	Remove impacted ear wax	1,322,628	8	0	2	5	2	0	10	2													19	0.61	0.75
70355	Panoramic x-ray of jaws	28,678	4	XXX	2				5	1													6	0.20	0.20
71010	Chest x-ray	18,282,814	4	XXX	2	1			3	1													5	0.18	0.18
71020	Chest x-ray	15,676,163	4	XXX	2	1			3	1													5	0.22	0.22
71260	Ct thorax w/dye	1,971,811	4	XXX	2	3			15	5													23	1.24	1.24
72192	Ct pelvis w/o dye	1,222,624	4	XXX	2	3			10	5													18	1.09	1.09
72193	Ct pelvis w/dye	2,308,971	4	XXX	2	3			10	5													18	1.16	1.16
73100	X-ray exam of wrist	458,439	4	XXX	2	1			3	1													5	0.16	0.16
73110	X-ray exam of wrist	753,523	4	XXX	2	1			3	1													5	0.17	0.17
73120	X-ray exam of hand	296,490	4	XXX	2	1			3	1													5	0.16	0.16
73130	X-ray exam of hand	755,783	4	XXX	2	1			3	1													5	0.17	0.17
73140	X-ray exam of finger(s)	310,708	4	XXX	2	1			2	1													4	0.13	0.13
74000	X-ray exam of abdomen	1,838,163	4	XXX	2	1			3	1													5	0.18	0.18

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
74020	X-ray exam of abdomen	994,189	4	XXX	2	1			3	1													5	0.27	0.27
74022	X-ray exam series, abdomen	1,089,991	4	XXX	2	1			5	1													7	0.32	0.32
74150	Ct abdomen w/o dye	1,315,665	4	XXX	2	3			12	5													20	1.19	1.19
74160	Ct abdomen w/dye	2,145,140	4	XXX	2	3			15	5													23	1.27	1.27
76075	Dxa bone density, axial	2,426,361	4	XXX	4	1			4	1													6	0.30	0.20
76519	Echo exam of eye	1,322,402	8	XXX	2	5	7	0	5	0													17	0.54	0.54
76700	Us exam, abdom, complete	1,329,410	4	XXX	2	3			10	4													17	0.81	0.81
76830	Transvaginal us, non-ob	325,124	4	XXX	2	3			12	5													20	0.69	0.69
77263	Radiation therapy planning	276,554	4	XXX	2				75														75	3.14	3.14
77280	Set radiation therapy field	240,934	4	XXX	2				23														23	0.70	0.70
77290	Set radiation therapy field	348,188	4	XXX	2				70														70	1.56	1.56
77300	Radiation therapy dose plan	1,282,101	4	XXX	2				15														15	0.62	0.62
77315	Teletx isodose plan complex	152,581	4	XXX	2				45														45	1.56	1.56
77331	Special radiation dosimetry	321,893	4	XXX	2				30														30	0.87	0.87
77334	Radiation treatment aid(s)	1,087,833	4	XXX	2				35														35	1.24	1.24
77470	Special radiation treatment	139,703	4	XXX	2				55														55	2.09	2.09
78306	Bone imaging, whole body	722,160	4	XXX	2	5			8	5													18	0.86	0.86
78315	Bone imaging, 3 phase	139,583	4	XXX	2	5			10	5													20	1.02	1.02
78465	Heart image (3d), multiple	2,930,407	4	XXX	2	5			20	5													30	1.46	1.46
78478	Heart wall motion add-on	2,765,566	4	XXX	4				10	1													11	0.62	0.50
78480	Heart function add-on	2,766,786	4	XXX	4				5	1													6	0.62	0.30
88309	Tissue exam by pathologist	200,175	4	XXX	4				90														90	2.28	2.80
88321	Microslide consultation	155,079	4	XXX	4				50														50	1.30	1.63
88323	Microslide consultation	34,714	4	XXX	4				56														56	1.35	1.83
88325	Comprehensive review of data	21,487	4	XXX	4				80														80	2.22	2.50
92083	Visual field examination(s)	2,434,073	8	XXX	2	3	0	0	10	0													13	0.50	0.50
92226	Special eye exam, subsequent	1,965,033	8	XXX	2	5	0	0	10	5													20	0.33	0.33
92235	Eye exam with photos	1,560,890	8	XXX	2				28														28	0.81	0.81
92250	Eye exam with photos	1,697,307	8	XXX	2	0	0	0	9	5													14	0.44	0.44
93010	Electrocardiogram report	19,204,537	4	XXX	2				5	2													7	0.17	0.17
93015	Cardiovascular stress test	2,252,974	4	XXX	2	2			15	4													21	0.75	0.75
93018	Cardiovascular stress test	1,503,471	4	XXX	2	2			5	5													12	0.30	0.30
94010	Breathing capacity test	1,237,293	4	XXX	2				5	2													7	0.17	0.17
95144	Antigen therapy services	303,805	4	0	2				3														3	0.06	0.06
95165	Antigen therapy services	6,017,763	4	0	2				3														3	0.06	0.06
95816	Eeg, awake and drowsy	228,893	4	XXX	2	5			15	10													30	1.08	1.08
95819	Eeg, awake and asleep	389,584	4	XXX	2	5			20	10													35	1.08	1.08
95861	Muscle test, 2 limbs	295,258	4	XXX	2	15			25	10													50	1.54	1.54
95872	Muscle test, one fiber	909	4	XXX	1	15			60	20													95	1.50	3.00
95900	Motor nerve conduction test	1,365,558	4	XXX	2	4			6	4													14	0.42	0.42
95904	Sense nerve conduction test	2,749,528	4	XXX	2	4			5	3													12	0.34	0.34
95925	Somatosensory testing	44,977	4	XXX	2	6.5			15	10													31.5	0.54	0.54
95926	Somatosensory testing	68,412	4	XXX	2	6.5			15	10													31.5	0.54	0.54
95927	Somatosensory testing	2,953	4	XXX	2	6.5			15	10													31.5	0.54	0.54
95953	EEG monitoring/computer	9,284	4	XXX	4	10			60	15													85	3.08	3.30
99201	Office/outpatient visit, new	465,665	5	XXX	2	3			10	5													18	0.45	0.45
99202	Office/outpatient visit, new	2,742,495	5	XXX	2	5			15	5													25	0.88	0.88

2005 Five Year Review Physician Time

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99203	Office/outpatient visit, new	5,007,937	5	XXX	2	5			25	10													40	1.34	1.34
99204	Office/outpatient visit, new	3,201,161	5	XXX	4	5			40	12													57	2.00	2.30
99205	Office/outpatient visit, new	1,097,515	5	XXX	4	10			50	15													75	2.67	3.00
99211	Office/outpatient visit, est	10,445,542	5	XXX	2	0			5	3													8	0.17	0.17
99212	Office/outpatient visit, est	26,139,270	5	XXX	2	3			10	5													18	0.45	0.45
99221	Initial hospital care	518,754	5	XXX	4	10			30	13													53	1.28	1.88
99222	Initial hospital care	3,486,006	5	XXX	4	15			40	20													75	2.14	2.56
99223	Initial hospital care	5,721,509	5	XXX	4	20			55	25													100	2.99	3.78
99231	Subsequent hospital care	20,534,153	5	XXX	4	5			15	5													25	0.64	0.76
99232	Subsequent hospital care	50,336,836	5	XXX	4	10			20	10													40	1.06	1.30
99233	Subsequent hospital care	17,225,862	5	XXX	4	10			25	15													50	1.51	2.00
99238	Hospital discharge day	6,416,301	5	XXX	2	9			20	10													39	1.28	1.28
99239	Hospital discharge day	2,279,088	5	XXX	4	10			30	15													55	1.75	1.90
99241	Office consultation	456,792	5	XXX	2	5			15	5													25	0.64	0.64
99242	Office consultation	1,767,974	5	XXX	4	5			25	10													40	1.29	1.34
99243	Office consultation	4,897,411	5	XXX	4	10			35	10													55	1.72	1.88
99244	Office consultation	5,512,793	5	XXX	4	10			45	15													70	2.58	3.02
99245	Office consultation	2,122,524	5	XXX	4	15			60	20													95	3.42	3.77
99251	Initial inpatient consult	366,384	5	XXX	4	5			20	5													30	0.66	1.00
99252	Initial inpatient consult	1,157,331	5	XXX	4	5			35	10													50	1.32	1.50
99253	Initial inpatient consult	3,391,552	5	XXX	4	10			40	15													65	1.82	2.27
99254	Initial inpatient consult	5,626,795	5	XXX	4	15			50	20													85	2.64	3.29
99255	Initial inpatient consult	2,817,081	5	XXX	4	20			60	25													105	3.64	4.00
99281	Emergency dept visit	178,635	5	XXX	4	2			7	4													13	0.33	0.45
99282	Emergency dept visit	1,095,199	5	XXX	4	3			10	5													18	0.55	0.88
99283	Emergency dept visit	5,159,423	5	XXX	4	5			18	7													30	1.24	1.34
99284	Emergency dept visit	5,520,136	5	XXX	4	5			25	10													40	1.95	2.56
99285	Emergency dept visit	6,534,826	5	XXX	4	8			40	15													63	3.06	3.80
99291	Critical care, first hour	2,960,371	5	XXX	4	15			40	20													75	3.99	4.29
99292	Critical care, addl 30 min	340,790	5	ZZZ	4				30														30	2.00	2.15

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Recommendations - Dermatology and Plastic Surgery

The following members of Workgroup met on August 25th to review work relative value recommendations for craniofacial, mohs surgery, excision of lesions, other plastic surgery, and other dermatology services: Barbara Levy, MD (Chairwoman), James Anthony, MD, Mary Foto, OTR, Charles Koopmann, Jr, MD, J. Leonard Lichtenfeld, MD, and Samuel D. Smith, MD. The RUC reviewed and approved these recommendations at their September 29-October 2, 2005 meeing.

Hidradenitis

The American Society of Plastic Surgeons (ASPS) submitted the hidradenitis services (CPT codes 11450, 11451, 11462, 11463, 11470, and 11471) as undervalued as the specialty argued that incorrect assumptions made in previous Harvard evaluation. The specialty stated that the entire family is undervalued as the post-operative time is low. The specialty conducted a survey, but received a very low response rate. Therefore, ASPS withdrew this family of codes from the Five-Year Review.

Craniofacial Surgery

ASPS also submitted comments to CMS to review the following ten craniofacial surgery codes: 21145, 21146, 21147, 21365, 21366, 21395, 21432, 21433, 21436, and 21470. The specialty argued that there are anomalous relationships between these codes and other codes. The specialty conducted a survey for each of these ten codes, but received a very low response rate for most of these services. Therefore, ASPS withdrew six of these codes (21365, 21366, 21432, 21433, 21436, and 21470) from the Five-Year Review.

The specialty did present survey data for codes 21145, 21146, 21147, and 21395 to the RUC. The specialty argued that there is compelling evidence that these codes had been valued based on an incorrect assumption regarding the value of the bone graft portion of the service. The specialty society and the RUC had agreed in April 1995 that the appropriate increment of work was 2.00. The basis for this decision is unclear. The committee agrees that the appropriate increment of work for the bone graft should be 50% of 20902 *Bone graft, any donor area; major or large* (7.54 * 50% = 3.77). The RUC recommends that this appropriate increment of 3.77 be utilized and added to the base code for each of these services.

Other Plastic Surgery Services

ASPS submitted five other miscellaneous services to the Five-Year Review, including: 11960, 15831, 19361, 43496, and 49906. The rationale for submission of these codes was largely based on a statement that incorrect assumptions were made in previous valuation or there had been changes in the service over the past ten years. ASPS surveyed each of these service, but was unable to obtain an adequate response rate and withdrew codes 11960, 19361, 43496, and 49906. The RUC agreed with the specialty that a CPT proposal should be completed for the services currently described in CPT code 15831 to capture the new population of patients presenting for excision of excessive skin and subcutaneous tissue in the lower abdomen, because of the tremendous increase in bariatric procedures for massive weight loss.

CMS submitted the following other plastic surgery services as the services had never been reviewed by the RUC: 15100, 15240, 15734. The specialty surveyed these three codes and the RUC was convinced that the survey data validated the current valuation of these service. 15732 was submitted by CMS because the service had been valued as an inpatient service and it is now performed as an outpatient service. After survey and discussion, it became apparent that CPT code 15732 describes two disparate procedures, allowing both superficial repairs and repair of more serious cancer defects to be reported with 15732. The plastic surgeons will coordinate with otolaryngology and ophthalmology to develop a coding proposal to specifically identify these services in new CPT codes.

Other Dermatology

The AAD and DUSA submitted CPT code 96567 *Photodynamic treatment, skin* and commented that the original vignette failed to recognize the degree of pain associated with this treatment and the consequent need for physician involvement. The RUC had reviewed this service in April 1991 and rejected the specialties recommendation at that time that the service required physician involvement. Dermatology has re-surveyed the code and presented the information to the RUC. After extensive discussion with the RUC regarding the potential need for further CPT revisions, the specialty decided to instead withdraw the code from the Five-Year Review.

CMS submitted several other integumentary services for review, including the following seven codes because they had never been reviewed by the RUC: 11100, 12052, 13121, 14040, 14060, 17262, and 17281. The specialty surveyed these seven codes and the RUC was convinced that the survey data validated the current valuation of these service.

CMS also CPT code 17003 *Destroy lesions, 2-14, each*, because advances in technology have likely resulted in a modification to the physician work required to accomplish the procedure. At the meeting, CMS staff noted that the new Medicare coverage policies related to actinic keratoses (AK) has increased the reporting of this service to describe cryosurgical destruction of AK. The RUC reviewed previous and current survey data and agreed that the application of cryosurgery to each lesion requires no more than two minutes of physician time. Therefore the current work relative value overestimates this time-limited, low intensity service. The RUC discusses its specific recommendation and rationale for this code in the attached document.

Mohs Surgery

CMS referred the Mohs surgery codes 17304 and 17305 to the Five-Year Review as this family of services have never been surveyed and reviewed by the RUC. The specialty conducted surveys to collect data for these two codes. The Workgroup had an extensive discussion regarding the various steps in the performance of this procedure and the physician involvement and time for each of these steps/activities. The Workgroup reviewed the history of these services and discussed the following February 2003 RUC action:

> *The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion and anatomical site, rather than the number of specimens. The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated.*

To date, there have been no attempts to discuss the Mohs surgery section with the CPT Editorial Panel and efforts to reach consensus with the Mohs surgery community on a coding proposal has been unsuccessful. RUC agreed with the prior conclusions of the RUC and is unable to validate the current work relative values absent a fundamental coding change within this section of CPT.

Excision of Lesions

CMS submitted all of the excision of lesion codes (benign: 11400-11446, malignant: 11600-11646), noting that these services have never been surveyed and reviewed by the RUC. The RUC first reviewed the history of the coding related to these services. In November 2001, the CPT Editorial Panel modified the nomenclature, changing the measurement of the lesion to include the lesion plus the margin required for complete excision. At the April 2002 RUC meeting, the RUC agreed with dermatology, family medicine, general surgery, and plastic surgery to determine new work relative values for these services using a mathematical model that 1) estimated 30% of benign lesions and 50% of malignant lesions would be reported with the next higher code as a result of the change in descriptors; 2) maintained the relative ratio between codes within each family; and 3) maintained budget neutrality within each family. CMS agreed with the RUC recommendations and the new codes and work relative values were implemented on January 1, 2003.

However, in *Proposed Rule* for the 2004 MFS, CMS indicated that they believe the work relative values for the excision of benign and malignant lesions of the same size should be equivalent. CMS proposed to utilize a weighted average approach for each code pair to establish new equivalent work relative value units. The RUC and several specialties commented in opposition to this proposal and requested CMS to seek additional input on this issue. In the *Final Rule* for the 2004 MFS, CMS agreed to postpone consideration of this issue until the specialties had opportunity to survey these codes and present data to the RUC.

The specialties provided an update to the RUC at the January 2004 meeting. The specialties indicated that they plan to survey a representative number of codes from each family of codes to offer evidence that there is a difference in physician work between the excision of benign and malignant lesions. The RUC extensively discussed this issue and raised a number of issues including whether pathology is known prior to the excision and if coding changes would be appropriate to change benign/malignant to superficial/deep. The RUC approved a methodology where the societies would survey one benign and malignant code from each of the three anatomic families (six codes total) to answer the question whether there is a difference in physician work.

After discussions at the January 2004 RUC meeting, specialty society Advisors from the specialties of dermatology, general surgery, otolaryngology, plastic surgery, and podiatry agreed to survey one code from each of the six benign/malignant excision code families. Common vignettes and a common reference list were developed. All six codes were surveyed by dermatology, general surgery, and plastic surgery societies. The two codes that reference *feet* (11423 and 11623) were surveyed by podiatry (utilizing an anatomical variation to the vignette). The four codes that reference *scalp* and *face* (11423, 11443, 11623, and 11643) were surveyed by otolaryngology. The RUC agreed that the results of these surveys respond to CMS' request to prove that there is a difference in physician work for excising benign and malignant lesions with similar diameters.

The RUC did consider comments from the American Academy of Family Physicians regarding a request to further clarify the CPT descriptors for these services. The RUC understands that there may be inconsistent payment policies regarding whether one must wait for a pathology report prior to submitting claims for these services. The RUC suggested that specialties pursue this issue with the CPT Editorial Panel if they believe it to be necessary. The CPT Editorial Panel did discuss this issue at their May 2004 meeting and understands that representatives from Dermatology will submit language to the Panel to clarify the guidelines for these services.

The following specialties were involved in conducting surveys in the summer of 2005 to review each of the excision of lesion codes: dermatology, plastic surgery, general surgery, otolaryngology, and podiatry. Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the RUC utilized the survey data for time for those codes for which there was an adequate sample size and the did their best to extrapolate that data to all codes.

In general, the RUC utilizing the following general principles in reviewing these codes:

1. Pre-time positioning and scrub time is not required for small lesions excised in the office.

2. The intra-service time varies by size of lesion only and remains consistent between anatomical sites.

3. For all but the largest benign lesion, a 99212 would be the typical office visit.

4. All of the malignant lesions require a 99213 in the 010 day global period to discuss the lab report with the patient.

The RUC agrees that the primary difference in the work between the excision of a benign versus a malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE - YEAR REVIEW

RUC 2 – ORTHOPAEDIC SURGERY

RUC RECOMMENDATIONS

The American Academy of Orthopaedic Surgery, The Musculoskeletal Tumor Society, the Orthopaedic Trauma Association, The American Society of Shoulder and Elbow Surgeons, The American Society for Surgery of the Hand, and the American Society of Hip and Knee Surgeons made presentations to the RUC for codes that were identified as misvalued due to changes in the patient population, rank order anomalies, and due to CMS submission.

The American Academy of Orthopaedic Surgery and the Musculoskeletal Tumor Society presented three families of tumor procedures.

Family 1: Excision of Deep Soft Tissue Mass (23076, 27328, 21556, 24076, 25076, 27048, 27619, 28045)
Family 2: Radical Resection of Soft Tissue Sarcoma (24077, 27329, 25077, 27049, 27615)
Family 3: Radical Resection of Bone Sarcoma (23220, 27365, 23200, 23210, 24150, 24152, 25170, 27076, 27078, 27645, 27646, 27647)

For all three families the specialties utilized a mini survey methodology. The RUC reviewed the methodology and expressed concern that some of the codes may not have met the previous RUC standard of low volume at less than 1,000 cases per year of Medicare volume. The presenters stated that many of these procedures are evenly distributed across the non-Medicare population so the total volume is higher than the Medicare volume. However, the RUC agreed to review the data as the RUC has never defined “low volume” for purposes of mini-surveys.

The presenters made the following case for compelling evidence to change the relative values of the tumor codes.

During the past 10 years, significant advancement has been made in the treatment of bone and soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors of bone and soft tissue, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas.

As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue and bone resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors of bone and soft tissue are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

The excision of deep benign masses (e.g. desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy etc. Again, these deep seated tumors are typically large at the time of initial presentation. Many lesions which were previously thought to be unresectable have increasingly been treated with surgical excision to the benefit of patients.

<u>Family 1: Excision of Deep Soft Tissue Mass</u> (23076, 27328, 21556, 24076, 25076, 27048, 27619, 28045)
The RUC examined the survey results and concluded that the survey data did not reflect the typical patient as identified in the Medicare data. Because the survey results described a hospitalized patient but the Medicare data indicate that only 7% to at the most 37% of patients receiving these procedures are hospitalized. Therefore, the RUC determined that the survey data could not be used and determined that there were two distinct patient populations being reported with these codes. This is most likely due to ambiguous CPT descriptors. Therefore based on the survey data and the Medicare data and absent any compelling evidence data from the presenters the RUC recommended referring the codes to CPT for clarification of "deep" excision and possibly creating new codes to differentiate based on the size and depth of the tumor.

Family 2: Radical Resection of Soft Tissue Sarcoma (24077, 27329, 25077, 27049, 27615)
The RUC found the same inconsistencies between the survey data and the Medicare data in that the survey data describes a hospitalized patient but the Medicare data indicate that only codes 27329 and 27049 have more than 50% of patients treated as inpatients. The RUC decided to refer this family to CPT for clarification.

Family 3: Radical Resection of Bone Sarcoma (23220, 27365, 23200, 23210, 24150, 24152, 25170, 27076, 27078, 27645, 27646, 27647)
The RUC examined this family of codes as an entire family. The RUC discussion focused on the issue of whether there may be different patient populations covered by each of these codes as was the case for tumor families 1 and 2 that were referred to CPT for additional clarification. If there are different populations, the RUC examined whether this warranted the creation of additional codes to differentiate superficial and malignant procedures. The RUC discussed this issue in detail and although all of these codes are predominantly performed in the inpatient setting according to Medicare data, the workgroup felt that additional clarification of the codes was warranted. The RUC suggested that the codes may need to be differentiated between malignant and benign or by the size of the tumor. The workgroup also strongly recommends that all appropriate specialty societies participate in the code development process. This recommendation was supported by the presenting specialty society.

For code 27647 the RUC requested to examine the AAOS and APMA data separately since podiatry performs 56 percent of the procedure. The RUC examined the survey data and determined that there was no compelling evidence to change the value of this procedure. Based on Medicare data, podiatry is the typical provider of this service and an examination of the podiatry survey data resulted in a median RVU of 12.78 with significantly lower intra-service time, therefore there was not sufficient evidence to increase the value to the requested RVU of 20.00. Additionally the RUC was concerned that the APMA data was based on a mini-survey that did not include an anchor code and a full RUC survey. Also, the RUC was not convinced that the size of the typical tumor has changed for this procedure.

Trauma (20680, 20692, 24430, 27465, 27470, 27472, 27709, 27720)
The RUC agreed that these codes should be examined for potential rank order anomalies. The RUC was concerned that code 20692 is a modifier 51 exempt code and codes 27472 and 27720 have values based on the value of 20902 *Bone graft, any donor area; major or large.* These are all codes with 90 day global periods, therefore codes 20692, 27472, and 27720 are being referred to CPT to obtain a

rational for why codes with 90 day global periods that have pre and post service times are modifier 51 exempt. The RUC was concerned that attempting to value these three codes would lead to double counting of some work.

Total Elbow (24363) and General (20600, 20610, 29075)
CMS submitted codes 20600, 20610, and 29075 because the codes have never been reviewed by the RUC. The RUC rejected the recommended RVUs for all of these codes and for code 24363 the value was set equal to code 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (RVW = 21.07), and the RUC agreed to maintain the current values of all the general orthopedic codes.

Wrist, Hand, Finger (25447, 26055, 26160, 26600, 26951, 64702, 64721)
Standard RUC surveys were conducted for each code and in some cases the RUC recommends increasing the current value to correct rank order anomalies. In other cases the new survey time was felt to be more accurate than the Harvard times, but the recommended increase in work RVUs were not accepted by the RUC. All but code 64702 were submitted by CMS because the codes had never been reviewed by the RUC.

Total Joint and Hip Fracture (27130, 27447, 27236)
These three codes were placed in the five-year review by CMS. The RUC workgroup reviewed these codes in August and assigned action key 2, No Change, because the specialty developed its recommendations based solely on NSQIP data and a Medicare DRG database. The specialty conducted a survey but concluded that it was faulty because the vignettes did not describe a typical patient. The specialty did not provide this survey data to the workgroup. The workgroup then requested the specialty to conduct a survey for the September RUC meeting with the understanding that the workgroup chair would extract the codes.

The specialties presented recommendations primarily based on survey data, however, the recommendations were supplemented by NSQIP and data for intra-service time. In addition the specialties then compared the codes with other RUC reviewed codes to show that the recommended values and times placed the codes in proper rank order.

The RUC began its review by reducing the preservice times for all three codes. The workgroup then discussed in detail the use of survey intra-service time as opposed to NSQIP time. For example, code 27130 has 135 minutes of NSQIP intra-service time as opposed to 110 minutes based on the survey. The specialties stated that the survey intra-service time of 110 minutes did not fully capture all of the intra-service time and

compared this time to NSQIP time of 135 minutes and a CMS DRG time of 144 minutes. The specialty explained that their methodology was to use the surveyed number and level of hospital vists when that survey derived length of stay equaled the NSQIP length of stay. This was used for codes 27130 and 27447. For 27236 the specialty chose to assign a number and level of visits based on the NSQIP length of stay because the specialty felt that the NSQIP length of stay was in proper rank order in comparison to the other two codes under review and the survey underestimated the visits.

The RUC discussed whether the NSQIP intra-service time should be used instead of the survey data and agreed for these three codes to use NSQIP intra-service times, recognizing that for codes 27130 and 27447 the NSQIP time is higher and for code 27236 the NSQIP time is lower. For code 27236 the specialty recommended using the NSQIP length of stay of six days as opposed to the imputed survey derived length of stay of five days. Other that these exceptions for intra-service time and length of stay for 27236, all other time data is based on the survey.

Some RUC members were uncomfortable with mixing NSQIP and survey data as opposed to using only survey data, but the specialty explained that the NSQIP intra-service time was felt to be more valid and also consistent with the DRG database. Additionally for codes 27130 and 27447 the survey imputed length of stay matched the NSQIP length of stay data so the survey hospital visit data was felt to be validated by NSQIP. For 27236 the NSQIP length of stay data was used because it placed the hospital visit data in proper rank order. Also, the specialties stated that the NSQIP intra-service time was more consistent among the three codes as the survey intra-service times were inconsistent. For example, the survey intra-service time for 27236 was 120 minutes and 27130 was 110 minutes. According to the presenters the relationship between the two codes are exactly the opposite and 27236 should have a higher intra-service time and the survey times were flawed. Therefore to preserve proper rank order in intra-service time, the workgroup recommends using the NSQIP derived intra-service times for all three codes. Additionally, the workgroup examined the IWPUT values based on these times and felt that resulting intensities supported using these times.

The RUC also compared the specialty recommendation with the existing Harvard times. The survey data suggests a decrease in length of stay for each of the codes but the presenters argued that although there are now fewer hospital visits, the total amount of work has not changed because the hospital and office visits are at a higher level and are more intense since the patients are discharged earlier. The presenters also questioned whether the CMS assigned number and level of post-service vists were accurate.

Based on a review of the survey data and the NSQIP data for intra-service time as well as a comparison to other reference codes, the workgroup did not see any compelling evidence for changing the current work RVUs. The RUC did agree to maintain the current work relative values but to accept the new physician times.

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Recommendations – Gynecology/Urology/Pain Medicine/Neurosurgery

Obstetrics and Gynecology

The American College of Obstetrics and Gynecology (ACOG) expressed an interest in developing RUC recommendations for 20 codes for the Five Year Review. Of the 20 codes, ACOG withdrew 10 codes from the consent calendar and Centers for Medicare and Medicaid Services (CMS) withdrew one code, 58260. Of the remaining codes, four codes (57500, 58120, 58150 and 58720) were identified by CMS because the service has never been reviewed by the RUC or the service has experienced a change in technology. The remaining codes (57160, 57240, 57250, 57260 and 57265) were identified by the ACOG because of changes in technology, anomalous relationships between existing codes and because the service has never been reviewed by the RUC. Of the remaining nine codes, ACOG did not believe the work values accurately reflected the amount of physician work for seven codes and recommended to maintain the values of two codes. For all nine codes, a full RUC survey was utilized.

Of the nine codes presented with survey data, the RUC valued six codes, but below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued due to compelling evidence such as rank-order anomalies, changes in patient population and incorrect assumptions were made in the previous valuation of the service. The RUC maintained the existing RVUs for three codes. For one of the three codes (57160), the RUC felt there was a lack of compelling evidence to change the RVU and for the other two codes (58120 and 58720), the RUC agreed with the specialty society that the survey data collected validated the existing times and existing RVUs.

Urology

The American Urological Association (AUA) expressed an interest in developing RUC recommendations for 12 codes for the Five Year Review. Of the 12 codes, the Coalition for the Advancement of Prosthetic Urology (CAPU), the original commenter, withdrew four codes from the consent calendar. Of the remaining eight codes, seven codes (50590, 51720, 52000, 52204, 52601, 55700 and 57288) were identified by CMS because of changes in technology or the service has never been reviewed by the RUC. The remaining

code, 51798 was identified by the AUA to reaffirm its recommendation to CMS. AUA did not believe the work values accurately reflected the amount of physician work for six codes and recommended to maintain the values of two codes. For all eight codes, a full RUC survey was utilized.

Of the eight codes presented with survey data, the RUC accepted one of the specialty society's recommendations to increase the existing RVUs. This procedure, 51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging, originally was reviewed by the RUC in April 2002. The RUC approved 0.38 work RVUs to reflect the physician work associated with this procedure. The RUC at this time would like to reaffirm the previous RUC recommendation of 0.38 work RVUS for this procedure.

The RUC increased five codes below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued due to changes in technology, changes in patient populations and incorrect assumptions were made in the previous valuation of the service. The RUC maintained the existing RVUs for two codes. For one of the two codes, The RUC felt that the work currently associated with the code is accurate and for the other code the RUC agreed with the specialty society that the survey data collected validated the existing RVUs.

Spine Surgery

The North American Spine Society (NASS) with several other specialty societies including American Society of Neuroradiology, Society of Interventional Radiology, American Academy of Orthopaedic Surgeons, American Association of Neurological Surgeons and the American College of Radiology, expressed an interest in developing RUC recommendations for seven codes, 22520, 22554, 22612, 22840, 63047, 63048 and 63075. These seven codes were identified by CMS because of changes in technology or because the RUC never reviewed this service. Of the seven codes, NASS did not believe the work values accurately reflected the amount of physician work for 5 codes the codes and recommended to maintain the work of two codes. For these seven codes the NASS utilized an alternative methodology approved by the Research Subcommittee and the RUC. This alternative methodology is as follows: The North American Spine Society (NASS) requested to use a modified and shortened RUC survey for seven codes in an attempt to increase the response rate. Because these are high volume codes and because these codes are linked to many other spine surgery codes, NASS wanted to survey a large number of surgeons and felt that the existing RUC survey would not result in a high response rate. NASS proposed a modified version of the standard RUC survey that will gather traditional RUC time data for the pre, intra, and

post service periods for each of the seven codes. For intensity and complexity, however, NASS will collect data on the changes that have occurred during the past 5-10 years in the performance of these procedures rather than the absolute numbers collected by the standard RUC survey. The Research Subcommittee had a number of concerns with this approach due to the lack of comparison with reference codes. The Subcommittee modified the proposed methodology so that reference codes are incorporated in the methodology. The Research Subcommittee suggested that the specialty utilize the modified survey but the survey should include two reference services that will be surveyed so the data can be compared to reference services. In addition the survey would include the intensity questions from the RUC survey but the survey respondents will be asked to indicate the changes if any during the past 5-10 years in the complexity and intensity for each component. The research subcommittee recommended approval of the following alternative methodology for NASS:

The specialty may use a modified RUC survey for codes 22520, 22554, 22612, 22840, 63047, 63048, and 63075 that will include surveys of time (pre, intra-service, immediate post-service), post op visits and estimates of total work. In the table surveying changes in intensity and complexity, two reference codes will be included and surveyed.

NASS conducted its survey online and quarantined the initial 14 web-based responses based on feedback from the RUC. The feedback was specific to two issues. One was the usage of language in the length of stay section (Survey question #3). The exact text seen in the 14 quarantined surveys was:

- Please estimate post-operative facility E&M services for the typical patient undergoing these procedures. (Refer to E&M code definitions provided on previous page.) The total number of visits identified below should add up to the number listed in question 2 (or less if you do not typically see the patient on the hospital floor the same day post op).
- Use a discharge service code (99238 and 99239) on discharge day if services you provide meet the definitions:

  Example 1: If LOS is 10 days; you might indicate, post op visit= 99231; and 99232=8 and 99238 on day of discharge
  Example 2: If LOS is 3 days; you might indicate, post op visit= none, and 99231=2; and 99238 on day of discharge
  Example 3: If outpatient; you might indicate 99238

The other issue involved the use of a default setting to "yes" for survey question #7 which queries if the vignette describes the typical patient. NASS removed the above text from question #3 and changed question #7 so there was no default setting on their web-based

survey. Their results from the quarantined surveys account for a very small percentage of their overall survey respondents. The RUC agreed with the specialty society that for this reason any difference between quarantined and non-quarantined results had no effect on the total results. The RUC also commended the specialty society in the manor in which they handled this issue.

The RUC accepted three of the specialty society's recommendations to decrease the existing RVUs for three procedures. The RUC agreed with the specialty society that these procedures were overvalued due to changes in length of stay and changes in physician time. The RUC accepted the specialty society's recommendation to maintain the work associated with two codes. The RUC agreed with the specialty society that the survey data collected validated the existing RVU associated with these codes. The RUC increased two codes below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued due to changes in length of stay and incorrect assumptions were made in the previous valuation of the service.

Spinal Pump Infusion and Stimulators

The American Academy of Pain Medicine (AAPM), North American Spine Society, American Association of Neurological Surgeons and the American Society of Anesthesiologists (ASA) expressed an interest in developing RUC Recommendations for 26 codes. AAPM and ASA, as the original commenters, withdrew all of these codes from the Five Year Review.

Aneurysm, Epilepsy and Skull Procedures

The American Association of Neurological Surgeons (AANS) expressed an interest in developing RUC recommendations for eight codes. Of these eight codes, four codes (61697, 61698, 61700, 61702) were identified by AANS because of changes in technique, technology and length of hospital stay and two codes (61537 and 61538) were identified by AANS because of an anomalous relationship between these codes and other codes within the craniotomy family. The remaining two codes (61154 and 61312) were identified by CMS because the service have never been reviewed by the RUC or because of advances in technology. For all eight codes, AANS did not believe the work values accurately reflected the amount of physician work for seven codes and recommended to maintain the work of one code. For the eight codes, a full RUC survey was utilized.

The RUC accepted three of the specialty society's recommendations to increase the existing RVU for three codes (61312, 61537 and 61538). The RUC agreed with the specialty society that this procedure is undervalued due to a change in the patient population and felt that survey results validated an appropriate increase. The RUC increased four codes (61697, 61698, 61700 and 61702) but below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures are undervalued due to change in technique, technology and length of hospital stay. The RUC maintained the existing RVUs for the remaining code (61154) as it felt that the work currently associated with this procedure is accurate.

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Workgroup 4 – Radiology/Pathology/Other Misc. Services
Recommendations

Representatives from the following medical specialties made work relative value recommendations to the RUC during its 2005 Five Year Review: radiology, radiation oncology, nuclear medicine, cardiology, endoscopy, pathology, neurology, allergy, anesthesia, and pulmonary medicine.

American Dental Association and the American Association of Oral and Maxillofacial Surgeons
CMS requested the RUC to review code 70355 Orthopanogram (Work RVU = 0.20) because it had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information). AAOMS conducted a random survey of 1,400 physicians using the RUC survey methodology and presented the results to the RUC for review. The survey results indicated that the code was slightly undervalued at its current level due to the time the respondents estimated for the service.

The RUC did not support an increase in the existing value as it was agreed that the specialty had not presented compelling evidence that the physician work had not changed. In addition, the specialty and the RUC agreed that the physician time from the survey was typically less than the survey results indicated.

American Society for Therapeutic Radiology and Oncology
CMS requested the RUC to review the following Radiation Oncology codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 77263, 77280, 77290, 77300, 77315, 77331, 77334, and 77470. The American Society for Therapeutic Radiology and Oncology (ASTRO) conducted a RUC survey of approximately 900 physicians with at least 100 respondents for each code. The survey results indicated that the Work RVUs for each code should be maintained at their current level, and ASTRO recommended no change in the work RVU.

The RUC agreed with the survey results and supported the specialty society's recommendation to maintain the work RVUs. The RUC found no compelling evidence to change the Work RVUs. In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the service being provided. Physician time for these procedures is recommended to be either maintained or less than current Harvard physician time.

American College of Radiology, American Academy of Orthopaedic Surgeons, and the American College of Obstetricians and Gynecologists

CMS requested the RUC to review the following imaging codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 71010, 71020, 71260, 72192, 72193, 73100, 73110, 73120, 73130, 73140, 74000, 74020, 74022, 74150, 74160, 76075, 76700, and 76830. The American College of Radiology (ACR) conducted a RUC survey for codes 71010, 71020, 71260, 72192, 72193, 74000, 74020, 74022, 74150, 74160, 76075, and 76700. ACR and the American Academy of Orthopaedic Surgeons (AAOS) conducted RUC surveys of 369 physicians with 77 respondents for codes 73100, 73110, 73120, 73130, and 73140. ACR and American College of Obstetricians and Gynecologists (ACOG) conducted a RUC survey of 279 physicians with 143 respondents for code 76830. The survey results from each of the societies indicated that the Work RVUs for each code should be maintained or increased from their current level.

The RUC agreed with the survey results and supported the specialty society's recommendation where the recommendation was to maintain the work RVUs. In addition, the RUC found no compelling evidence to change the Work RVUs, for those codes where the specialty recommended an increase. In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the service being provided. Physician time for these procedures is recommended to be maintained, higher, or lower than current Harvard physician time.

American College of Cardiology and the American College of Radiology

The American College of Cardiology (ACC) and American College of Radiology (ACR) recommended four cardiac imaging codes (75552, 75553, 75554, and 75555) to be sent to CPT for revision so that they may reflect current practice patterns. According to ACC and ACR, the current descriptions are confusing to members as well as payers for the services. The RUC agreed with the specialty society recommendation and recommends the family of codes be reviewed by the CPT Editorial Panel.

American College of Cardiology, American College of Radiology, and the Society of Nuclear Medicine

CMS requested the RUC to review the following codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 33208, 78306, 78315, 78465, 78478, 78480, 93010, 93015, 93018, and 93325. The American College of Cardiology (ACC) conducted a RUC survey on code 33208 involving 300 physicians with a response rate of 42.

The Society of Nuclear Medicine (SNM) and American College of Radiology (ACR) conducted a RUC survey for codes 78306 and 78315, involving 488 physicians with a response rate of over 80. SNM, ACR, and ACC conducted a RUC survey for codes 78465, 78478, and 78480 involving 574 physicians with over 100 respondents. ACC conducted a RUC survey for codes 93010, 93015, 93018, and 93325, involving several physicians with varying degrees of respondents. The survey results and recommendations from each of the societies indicated that the Work RVUs for each code should be either maintained or decreased from their current level.

The RUC found no compelling evidence to change the work RVUs and agreed with the survey results and supported the specialty society's recommendation to maintain the work RVUs for codes 33208, 78306, 78315, 78465, and 78478. Code 78480 was found to be not in the correct rank order and therefore overvalued by the RUC. Codes 93010, 93015, and 93018 were reviewed and the RUC found no compelling evidence to change the Work RVUs for these codes. However, code 93325 was referred to CPT by the RUC to be bundled with 93307.

In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the typical service being provided. Physician time for these procedures was recommended to be maintained, higher, or lower than current Harvard or RUC physician time.

<u>American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, Society of Interventional Radiology, and the American College of Radiology</u>

CMS requested the RUC to review the following endoscopy codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 43235, 43246, 43750, 45330, and 45378. The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a RUC survey on codes 43235, 43246,

45330, and 45378, involving 255 physicians with a response rate of over 60. The Society of Interventional Radiology (SIR) and the American College of Radiology (ACR) conducted a RUC survey on Code 43750 involving 398 physicians with a response rate of 57. The survey results and recommendations from each of the societies indicated that the Work RVUs for each code should be either maintained or increased from their current level.

The RUC agreed with the survey results and supported the specialty society's recommendation to maintain the work RVUs for codes 43235, 43246, 43750, 45330, and 45378. The RUC found no compelling evidence to change the Work RVUs. In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the typical service being provided. Physician time for these procedures was recommended to be maintained, or lower than current Harvard or RUC physician time.

American Academy of Pediatrics and the American Academy of Neurology

The American Academy of Pediatrics (AAP) brought forth nine codes for this Five Year Review, however eight were withdrawn by AAP after the 2006 Proposed Rule was made public. Code 62270 remained and was jointly requested for review by AAP and the American Academy of Neurology (AAN) as it had never been through the RUC for the consideration of physician work. AAP and AAN conducted a survey of panel of 53 physicians with 31 responses. The survey results and recommendation from the specialties indicated that the Work RVU was undervalued, particularly so for the work associated with the young child population.

The RUC believed that there is a bimodal distribution of physician work associated with the code, whereas there are two different typical patient types, infant and young children. The RUC and the specialties believed that the infant population requires less work than in the young child population. The RUC suggested that it may be reasonable for the specialties to eventually consider splitting the code into the two typical patient types to capture any differences in physician work. With regard to the current 62270 code, however, the RUC recommended that it should be valued higher and recommended a work RVU of 1.35.

American Academy of Neurology, American Clinical Neurophysiology Society, American Association of Neuromuscular & Electrodiagnostic Medicine, and the American Academy of Physical Medicine and Rehabilitation

The American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), and the American Academy of Physical Medicine and Rehabilitation

(AAPMR) brought forth in different groups, the following five neurology and neuromuscular codes for this Five Year Review: 95872, 95925, 95926, 95927, and 95953. In addition, CMS requested the RUC to review the following neurological codes because they had

never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 95816, 95819, 95861, 95900, and 95904. The specialties surveyed hundreds of physicians for information on these codes and received over 30 respondents on most

of these services. The survey results and recommendations from the specialties indicated that the Work RVU was either currently correctly valued or undervalued.

The RUC agreed with the survey results and supported the specialty society's recommendation to maintain the work RVU for codes 95816 and the RUC found no compelling evidence to change the Work RVUs. Codes 95819, 95861, 95900, 95904, 95925, 95926, and 95927 were reviewed and the RUC found no compelling evidence to change the Work RVUs. However, codes 95872, and 95953 were found to have compelling evidence to increase the RVU above their existing values. In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the typical service being provided. Physician time for three of these procedures was recommended to be lower than current Harvard or RUC physician time.

Joint Council of Allergy, Asthma, and Immunology and the American Academy of Otolaryngic Allergy

The Joint Council of Allergy, Asthma, and Immunology (JCAAI) and the American Academy of Otolaryngic Allergy (AAOA) brought forth the following five codes without work relative values for this Five Year Review based on their understanding that physician work was inherently in the service: 95004, 95024, 95027, 95115, and 95117. In addition, CMS requested the RUC to review the following neurological codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 95144 and 95165. The JCAAI and AAOA conducted surveys of 164 physicians and received at least 20 respondents for each code. The survey results and recommendations from the specialties indicated that the there was physician work in those codes currently with zero work values, and greater physician work for the codes were there currently is a work RVU.

The RUC reviewed the specialty society recommendations and survey results and referred the specialty to CPT Editorial Panel for clarification and possible revision at the CPT level for specific physician work codes for codes 95004, 95024, and 95027. The specialty withdrew codes 95115 and 95117 from consideration, and the RUC agreed that the current work RVUs were appropriate for codes

95144 and 95165, as there was no compelling evidence for a change. The RUC and the specialty agreed on physician time data for codes 95144 and 95165 to reflect the typical patient encounter.

College of American Pathologists

The College of American Pathologists brought forth the following four codes for review by the RUC during this Five Year Review because of changes in cancer protocols and the content of work: 88309, 88321, 88323, and 88325. The survey results and recommendation from the specialties indicated that the Work RVU was undervalued.

The RUC reviewed the specialty's survey results for each code and agreed with the specialty that they were undervalued for the increased physician work now involved in the service. The change in work was due to the increased number and type of slides undergoing review in the typical case, and in particular, the number of immunohistochemical slides that must undergo review. The RUC also believed that the clinical practice of these pathology consultations had changed based on recent literature. The RUC believed the specialty had presented compelling evidence to change the relative work value for each code. In addition, the RUC and specialty believed the 25th percentile survey results reflected the true physician work for each of the codes..

American Society of Anesthesiologists

The American Society of Anesthesiologists (ASA) requested that the RUC review code 00797 Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity. The specialty believed that the increased awareness of gastric restrictive procedures has led to an increased understanding of the intensity and complexity of the anesthesia management involved. The ASA conducted a survey of 94 physicians resulting in 40 respondents indicating the physician work was undervalued for this code.

The RUC reviewed the survey results and specialty society recommendation and agreed with their recommended median base unit value and physician time for the code.

American College of Chest Physicians and the American Thoracic Society

CMS requested the RUC to review the following pulmonary medicine codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 31622, 94010, and 94657. The American College of Chest

Physicians (ACCP) and the American Thoracic Society (ATS) conducted a survey of 170 physicians resulting in at least 30 respondents for each code. The survey results and recommendations from the specialties indicated that the Work RVU was either currently correctly valued or undervalued.

The RUC reviewed the survey results and recommendations from the specialty for codes 31622, and 94010 and could not find a compelling reason to change the work RVUs for these codes. In addition, the RUC and the specialty agreed on typical physician time data elements from the survey results to reflect the typical patient encounter. The RUC did find compelling evidence to support the specialty society's recommendation and survey work value results for code 94657. The RUC discussed that a rank order anomaly would be created with code 94656, and therefore it should be reviewed at the February 2005 RUC meeting. In addition, the RUC and the specialty agreed on typical physician time data elements from the survey results to reflect the typical patient encounter for this code.

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Recommendations - Evaluation and Management Services

This document discusses the overall historical valuation of the Evaluation and Management (E/M) services; the process utilized to develop recommendations in this Five-Year Review; the E/M Workgroup Review, and the RUC recommendations. An attachment includes the recommendations for each individual E/M code. An Excel spreadsheet is also attached, summarizing the current and recommended physician time and physician work for each code.

Original Valuation of Evaluation and Management Services in 1992

On January 1, 1992, the Health Care Financing Administration (HCFA) implemented the Resource-Based Relative Value Scale (RBRVS) and assigned relative values for new Evaluation and Management codes, first published in *CPT 1992*. The work relative values for E/M were based on three phases of the Harvard study. The Harvard surveys were based on the pre-1992 CPT descriptors (eg, 90015,*Office and other outpatient medical service, new patient; intermediate service*) and typical patient vignettes. HCFA then worked with the Harvard researchers and the CPT Editorial Panel to develop a structure and intra-service time variation for the new 1992 CPT E/M codes.

The work relative values were then assigned to the codes utilizing a crosswalk process based on the typical patient vignettes. After the publication of the Final Rule in the November 25, 1991 *Federal Register,* HCFA received numerous comments that the E/M codes were undervalued. Specialty societies offered a number of different approaches on reviewing the intensity relativity of E/M. These approaches varied from ascending intensity within a family of E/M codes; descending intensity, or equivalent intensity. HCFA concluded that they would not reach consensus within the medical community. HCFA chose to continue to use Harvard data and value the E/M codes in a linear fashion, assigning a fixed intensity of intra-service work across all the codes in an E/M family (eg, office, established patients, and then multiplying that amount by the intra-service time to determine the new intra-service work values. HCFA then computed total work relative values by adding pre- and post-service work, which is calculated as a percentage of the intra-service work (eg, office, established patient = 35.1%). HCFA stated that "in absence of any further data, we do not believe changes more comprehensive than those we have made would be appropriate."

1995 Five-Year Review of the RBRVS

RUC Review:

In 1995, the RUC submitted new data and recommendations to HCFA for E/M codes in response to the first, Five-Year Review of the RBRVS. At that time, Internal Medicine and Family Medicine commented that the E/M codes should be re-evaluated for the following reasons:

- The physician work involved in the E/M services had increased since the time that the Harvard RBRVS study was conducted.
- The E/M services were undervalued relative to most of the other services in the RBRVS.
- The current CPT-coded services were never directly surveyed or studied in the Harvard RBRVS study.

Prior to conducting the surveys and developing relative value recommendations, the specialties involved agreed to the following:

- The clinical vignettes used in the surveys were those that had been validated by the CPT Editorial Panel and included in either the main CPT book or the clinical examples supplement (Appendix D).
- A standard set of reference services were chosen for use in the surveys.
- The issue of whether the intra-service work per unit of time (IWPUT) is the same or different for all levels of service within an E/M family had been addressed by HCFA in November 1992, less than three years prior to this first, Five-Year Review. HCFA had already concluded that IWPUT is constant within a family from the lowest to the highest level of service. Understanding that HCFA had made its decision on this point, the specialties decided to survey one or two codes within each family and then extrapolate to the other codes based on the IWPUT of the surveyed codes, retaining HCFA's decision that a constant IWPUT should be maintained for each level of service.

Approximately 150 respondents were obtained for each surveyed code. A median value was calculated for each specialty, and these values were weighted to develop the recommended work relative values. The weighting process took into account the percentage of the services that are provided by each specialty, the number of respondents from the specialty, and other factors affecting the validity of each specialty's survey process.

The RUC found the arguments made by the specialties and the results of the survey very compelling and recommended increases in the RVUs for office visits for new and established patients, subsequent hospital visits, and inpatient and outpatient consultations. In particular, the RUC found the surveyed RVUs produced a more reasonable relationship between E/M and non-E/M services on the RBRVS, with the ratio of total work to total time moving closer to the level that has been consistently identified for all other services. For example, the RUC agreed that the work of 99215 *Established Office Visit, Level V* should be greater than 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 to 7.5 cm* (work rvu = 1.86, intra-time = 22 minutes; total-time = 43 minutes).

In addition to the survey results, the RUC's recommendations were also based on rigorous multidisciplinary review by surgeons and other specialists who share the primary care groups' views regarding the increase in the work of E/M services in the previous five years and the failure of the current RVUs to appropriately recognize the time and effort involved in both intra- and post-service work. The RUC vote to adopt the recommendations to increase the E/M services was nearly unanimous.

The RUC's evaluation of these recommendations focused principally on the work involved in them, how that work has changed over time, and how the service work is related to the work of other E/M and non-E/M services. The survey respondents' rating of work appeared to be accurate. Some problems were noted in the survey results for post-service time, however. Within the survey instrument, the detailed questions related to post-service time appeared to lead to overestimates of total post-service time. This may have been due either to rounding, to overlap within the categories, or just to the tendency of survey respondents to want to fill in all the boxes on a survey. The RUC concluded, therefore, that although post-service time was underestimated in the Harvard survey as it did not reflect post-time in 1995, post-service time was likely overestimated in the RUC survey data. The correct estimate of post-service time is likely somewhere between these two estimates. The time estimates for hospital services were more problematic than the estimates for office services, because the intra-service period is defined as time on the patient's floor. Many services, such as arranging for further studies and reviewing results, could take place either on the patient's floor, elsewhere in the hospital, or in the

physician's office, thus making precise estimates difficult to obtain. The uncertainty surrounding the post-service time estimates did not affect the extrapolation from surveyed to non-surveyed services within a family, however. Extrapolation was based on work per unit of time, and this remained constant within each family whether the surveyed post-service times were used as is or were reduced by some percentage. The typical times listed in the CPT descriptors were used for this purpose.

HCFA Review:

In the *May 3, 1996 NPRM,* HCFA discussed its review of the RUC recommendations from the first, Five-Year Review of E/M. HCFA concluded that the work relative values for E/M are based on three basic assumptions. These three assumptions originated during the Harvard study and were held constant in both the 1992 and 1995 refinements:

1. All services within a family of evaluation and management services (eg, office visits) have the same intra-service work intensity.
2. The intra-service work times in the CPT descriptors are correct.
3. The pre-service and post-service work is a fixed percentage of intra-service work.

HCFA utilized 1989 and 1994 publications of the AMA's *Physician Marketplace Statistics* to identify that the median number of hours a physician works in patient care (51 hours) and the median number of patient visits per week (101) had not changed between 1989 and 1994. They further used this information to calculate the total number of hours that a physician would need to spend in patient care hours (78.5) to perform 101 visits, based on the 1995 RUC survey data. This was a key argument that HCFA utilized to reject the RUC survey time and recommendations.

Although HCFA did not agree with the RUC recommendations, the agency did agree that the E/M services should be increased. HCFA utilized a different approach to compute these increases. Using the above assumptions, HCFA increased the intra-service work intensity by 10 percent and fixed the percentage of pre- and post-service work in relation to intra-service work by 25%. For example, the intra-service intensity for established office visits was increased from 0.028 to 0.031 and the pre- and post-service work as a percentage of intra-service work was increased from 35.1% to 43.8%.

December 2004 Comment Letter to Initiate 2005 Five-Year Review of E/M

On December 16, 2004, twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first, Five-Year Review in 1995. The specialties provided the following reasons for the change in work in the past ten years:

- Medical practice has changed;
- A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness;
- Additional documentation requirements added to physician work;
- An increase in the complexity of the data to be evaluated and care to be managed;
- Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press;
- The advent of online communication with patients;
- A greater role for genomics in the evaluation and management of patients;
- Environmental changes (eg, increased volume, decreased number of facilities, increased uninsured population, and EMTALA requirements) in the emergency department;
- The intensity of EM services has increased over time;
- Hospital length of stay has changed

The societies also concluded that they believe E/M services are not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) the work per unit of time for E/M services is less than the work per unit of time for almost any other service.

Medical specialty society survey process

A coalition of medical specialty societies conducted surveys related to 35 E/M services over the summer of 2005. Physicians were contacted via e-mail and provided a link to a web-based survey, based on the standard RUC survey instrument. The specialties involved with this effort, coordinated by the medical specialties, included: anesthesiology, critical care medicine, dermatology, emergency medicine, endocrinology, family medicine, hematology, infectious disease, internal medicine, neurology, nursing, oncology, osteopathic medicine, podiatry, pulmonary medicine, and rheumatology. The number of survey respondents for each code ranged from a low of 40 respondents to a high of 245 respondents, with most codes having at least 80 respondents. The survey data were collated and presented with data by individual specialty society to the RUC on August 2, 2005.

Surgical specialty society survey process and coordination with medical specialty coalition

A coalition of surgical specialty societies had expressed an interest in developing recommendations for E/M in April 2005. Following preliminary discussions at the April RUC meeting, a surgical executive committee (SEC) met with a medical executive committee (MEC) to develop a common reference service list and to review and edit vignettes developed by the coalition of medical specialty societies. Several conference calls and e-mail communications were conducted to develop the reference service list and to critique the vignettes. The MEC responded by removing all references to physician work from the vignettes. Vignettes for codes predominately performed by other specialties, such as podiatry and dermatology for 99201 and 99202, were also modified to capture the typical patient evaluated by these specialties. However, complete consensus on the use of a single vignette for each CPT code and for the specific vignettes themselves was not achieved as the SEC continued to express concern regarding the vignettes. The MEC decided that it needed to move forward by initiating their surveys in early June.

The SEC subsequently initiated web-based surveys and planned to meet with the MEC in late July to review all survey data and attempt to come to consensus on a single set of recommendations to the RUC. At some point in mid-July, the SEC realized that their own survey data and analysis concluded that there should be no changes in the work relative values and suggested cancellation of the meeting as they would not be able to support modifications to the valuation of E/M. On August 2, 2005, the following surgical specialties signed a letter outlining their rationale (including summary survey data) for maintaining the current relative values for the E/M services: breast surgery, cardiothoracic surgery, cataract surgery, colon and rectal surgery, general surgery, hand surgery, neurosurgery, obstetrics and gynecology, orthopaedic surgery, otolaryngology, pediatric surgery, plastic surgery, spine surgery, transplant surgery, urology, vascular surgery. The Workgroup agreed that this submission was a "comment" rather than a "recommendation" as the surgical coalition did not submit a breakdown of survey results by specialty society and did not complete the RUC standard Summary of Recommendation forms. This coalition of surgical specialties also sent an additional letter on August 18, 2005 refuting the recommendations to increase the work relative values for E/M, submitted by the coalition of medical specialties.

RUC E/M Five-Year Review Workgroup

The following individuals were members of the RUC's Five-Year Review E/M Workgroup: Norman A. Cohen, MD (Chairman), John Derr, Jr., MD, David F. Hitzeman, DO, George Kwass, MD, Gregory Przybylski, MD, and Maurits J. Wiersema, MD. These individuals met periodically via conference call throughout the summer and also prepared by reviewing a collection of historical information regarding the previous studies and methodologies to evaluate the physician work related to the E/M services. The Workgroup sent a letter to all specialties who had expressed an interest in developing recommendations for E/M on June 7, 2005. This letter laid out the expectations of the Workgroup, including specific questions to be addressed by the specialties in their presentation. The Workgroup also stated that it required the data to be submitted with both overall results and breakdown of results by specialty society. The Workgroup, along with the Chair of the RUC and the Chair of Overall Five-Year Review project, also provided guidance regarding the use of a fair and consistent process to consider the valuation of the E/M services.

The RUC's E/M Five-Year Review Workgroup met on August 27 - 28, 2005 to consider the recommendations presented by the coalition of medical specialties and the comments by the coalition of surgical specialties.

Workgroup Recommendations

The Workgroup initially discussed the RUC's compelling evidence standards and considered the following arguments that were presented by the medical specialty societies:

- Nearly all of the E/M codes under review have never been surveyed with their actual CPT descriptor and a common vignette.
- CMS made incorrect assumptions when these services were evaluated in the 1995 Five-Year Review.
- The 1995 and 1997 E/M Documentation Guidelines have been fully implemented. In the first Five-Year Review, these 1995 documentation guidelines had been introduced, but not implemented. In addition, other insurers and accrediting agencies have required additional documentation.
- New diagnostic and screening tests have been developed in the past ten years, which add to the amount of data that needs to be considered and followed-up on as required.
- An increase in the number of clinical guidelines has occurred in the past ten years.
- A new emphasis on disease management and chronic care management requires more coordination of care with a team of providers.
- Patients are more informed and wish to be more active participants in their decisions regarding their medical care. Patient expectations are higher and they often come to the office armed with incorrect information from the Internet or lay press.
- The National Ambulatory Medical Care Survey (NAMCS), published by the Centers for Disease Control and Prevention, reflects an increasing complexity and intensity of physician work in office practice from 1999-2002. One reason for this increased complexity is the declining length of hospital stay and the treatment of these acute patients in the physician office setting.

The surgical representatives countered that the arguments regarding increased physician work did not reflect external data that state that physicians are not spending more time in E/M services. The NAMCS data suggests that in 1997, physicians spent an average of 18.8 minutes on each visit. In 2002, the visit duration has decreased to 18.4 minutes. The 1989 and 1994 publications of the AMA's Physician Marketplace Statistics indicated that the median number of hours a physician works in patient care is 51 hours per week and the median number of patient visits is 101. The 2001 median number of patient visits per week is 50 hours and the number of patient visits per week is 100. The medical representatives countered that they agree that the amount of intra-service time has not increased. However, the intensity has increased as physicians are required to do more in the same timeframe and the patient population is more complex.

The Workgroup also discussed the increased reporting of the higher level E/M codes and the resulting increased intensity that has been captured in the utilization of these CPT codes. The medical representatives explained that there has been an increase in the number of E/M services reported per beneficiary. In addition, the education regarding the 1995 and 1997 documentation guidelines has resulted in physicians reporting E/M correctly. The 1995 documentation guidelines were based on multi-system exams and the 1997 guidelines provided more flexibility in single system examinations, perhaps leading to more accurate E/M reporting for those specialties that focus on single systems. The medical representatives admitted that they are unable to fully explain the shift in utilization to the higher level E/M codes.

After extensive discussion, the Workgroup agreed that the compelling evidence to review these services is that **there is evidence that incorrect assumptions were made in the previous valuation of the service**. The Workgroup has reviewed the May 1996 *Notice of Proposed Rulemaking (NPRM)* and the HCFA rationale in evaluating the E/M in the 1995 Five-Year Review. Specifically, the Workgroup reviewed the following three assumptions made by HCFA at that time:

1. All services within a family of evaluation and management services (eg, office visits) have the same intra-service work intensity.
2. The intra-service work times in the CPT descriptors are correct.
3. The pre-service and post-service work is a fixed percentage of intra-service work.

The Workgroup also reviewed the RUC comment letter on this NPRM in June 1996, in which the RUC argued that the HCFA valuation of E/M was flawed, stating "The proposed values are based on several questionable assumptions that warrant further

evaluation." The Workgroup agrees that the assumptions made by HCFA are flawed and noted that HCFA stated at that time that "We will remain open to data receiving further information that shows the relationships between some families of these services have changed." The Workgroup agreed that this compelling evidence standard applied to the office visits, hospital visits, and consultations.

The critical care and emergency department visits were not based on the above three assumptions. Therefore, the Workgroup does not believe that this particular compelling evidence standard applies to these two families of services.

During the Workgroup meeting, the medical specialties and the surgical specialties provided additional information for consideration by the Workgroup. Because the Workgroup did not have adequate time to review this additional data during the limited period available for Workgroup deliberation, the Workgroup agreed to accept both submissions for informational purposes only.

The Workgroup reviewed each E/M code extensively, reviewing the survey from the coalition of medical specialties, comparing the codes to reference services, and considering comments from the surgical coalition and other meeting attendees. The Workgroup's specific E/M code recommendations were presented to the RUC on September 29 – October 2, 2005.

RUC Recommendations

The RUC agreed with the Workgroup that one of the compelling evidence standards was met and warranted the review of the E/M services. The RUC agreed that the compelling evidence to review these services is that **there is evidence that incorrect assumptions were made in the previous valuation of the service**.

This Five-Year Review included 47 E/M codes. **The detailed rationale for the recommendations for each code are attached to this document.** Twelve of these codes (nursing facility and domiciliary care) were referred to CPT and reviewed by the RUC at the April 2005 meeting. CMS will consider the RUC recommendations for these two families in their November 1, 2005 Final Rule, for implementation on January 1, 2006. On October 1-2, 2005, the RUC approved final recommendations for 26 codes, interim recommendations for 6 codes (99222, 99223, 99232, 99233, 99291, and 99291), and postponed review of 3 codes (99213, 99214, 99215) to the February 2006 meeting. The RUC now submits all of these recommendations to CMS for consideration for the Spring 2006 Proposed Rule. It is anticipated that the RUC will forward additional information and/or recommendations to CMS on the six interim and three postponed codes immediately following the February RUC meeting.

The RUC anticipates that it will review updated or refined survey data on the six codes submitted with “interim” values. The RUC's Rules and Procedures state the following regarding RUC "interim" recommendations:

The RUC may develop an “interim” relative value unit(s). If the RUC adopts an “interim” work relative value unit, the associated specialty society will be expected to present updated or refined survey data to the RUC at the next RUC meeting. If no subsequent data is presented which validates the interim values, the work relative unit will be deemed “not validated,” and CMS will be notified as such.

The RUC has postponed review of CPT codes 99213, 99214, and 99215 is to allow continued review, discussion, and reflection so the RUC may reach an appropriate resolution of this issue at the February 2006 RUC meeting.

RUC E/M Recommendations

	A	B	C	D	E	F	G	I	J	K	L	M	N	O	P	Q
1		Existing Data - RUC database						CPT	Workgroup Recommendations					RUC Recommendations		
2	Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Calc IWPUT	Time	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	Work RVU	IWPUT	
3	Office, new															
4	99201		10		15	0.45	0.034	10	3	10	5	18	0.45	0.45	0.027	
5	99202		20		30	0.88	0.033	20	5	15	5	25	0.88	0.88	0.044	
6	99203	5	24	24	53	1.34	0.029	30	5	25	10	40	1.34	1.34	0.040	
7	99204		45		68	2.00	0.033	45	5	40	12	57	2.03	2.30	0.048	
8	99205	10	45	55	110	2.67	0.027	60	10	50	15	75	3.00	3.00	0.049	
9	Office, estab															
10	99211		5	2	7	0.17	0.025	5	0	5	3	8	0.17	0.17	0.021	
11	99212		10	5	15	0.45	0.034	10	3	10	5	18	0.45	0.45	0.027	
12	99213		15	8	23	0.67	0.033	15	5	15	5	25	0.80	Postponed until 2/2006		
13	99214		25	13	38	1.10	0.032	25	5	25	10	40	1.30	Postponed until 2/2006		
14	99215		40	19	59	1.77	0.034	40	8	35	15	58	2.00	Postponed until 2/2006		
15	Initial hospital															
16	99221		30		43	1.28	0.033	30	10	30	13	53	1.88	1.88	0.045	
17	99222		50		71	2.14	0.033	50	15	40	20	75	2.56	2.56	0.044	Interim
18	99223	10	45	50	105	2.99	0.037	70	20	55	25	100	3.78	3.78	0.050	Interim
19	Subsequent hosp															
20	99231		15	4	19	0.64	0.037	15	5	15	5	25	0.76	0.76	0.036	
21	99232		25	5	30	1.06	0.038	25	10	20	10	40	1.30	1.30	0.043	Interim
22	99233		35	6	41	1.51	0.039	35	10	25	15	50	2.00	2.00	0.058	Interim

RUC E/M Recommendations

	A	B	C	D	E	F	G	I	J	K	L	M	N	O	P	Q
1		Existing Data - RUC database						CPT	Workgroup Recommendations					RUC Recommendations		
2	Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Calc IWPUT	Time	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	Work RVU	IWPUT	
23	**Hosp discharge**															
24	**99238**	6	18	12	36	1.28	0.049	) or le	**9**	**20**	**10**	**39**	**1.28**	**1.28**	**0.043**	
25	**99239**	9	20	16	45	1.75	0.060	re tha	**10**	**30**	**15**	**55**	**1.90**	**1.90**	**0.045**	
26	**Office consult**															
27	**99241**		15		23	0.64	0.031	15	**5**	**15**	**5**	**25**	**0.64**	**0.64**	**0.028**	
28	**99242**		30		45	1.29	0.032	30	**5**	**25**	**10**	**40**	**1.34**	**1.34**	**0.040**	
29	**99243**	5	30	31	66	1.72	0.030	40	**10**	**35**	**10**	**55**	**1.97**	**1.88**	**0.041**	
30	**99244**		60		88	2.58	0.033	60	**10**	**45**	**15**	**70**	**3.02**	**3.02**	**0.055**	
31	**99245**	10	48	50	108	3.42	0.043	80	**15**	**60**	**20**	**95**	**3.77**	**3.77**	**0.050**	
32	**Inpatient consult**															
33	**99251**		20		26	0.66	0.026	20	**5**	**20**	**5**	**30**	**1.00**	**1.00**	**0.039**	
34	**99252**		32		42	1.32	0.034	40	**5**	**35**	**10**	**50**	**1.50**	**1.50**	**0.033**	
35	**99253**	10	30	35	75	1.82	0.027	55	**10**	**40**	**15**	**65**	**2.27**	**2.27**	**0.043**	
36	**99254**		65		84	2.64	0.034	80	**15**	**50**	**20**	**85**	**3.29**	**3.29**	**0.050**	
37	**99255**	15	45	57	117	3.64	0.045	110	**20**	**60**	**25**	**105**	**4.00**	**4.00**	**0.050**	
38	**Emergency visit**															
39	**99281**		10		11	0.33	0.031	N/A	**2**	**7**	**4**	**13**	**0.33**	**0.45**	**0.045**	
40	**99282**		15		16	0.55	0.035	N/A	**3**	**10**	**5**	**18**	**0.55**	**0.88**	**0.070**	
41	**99283**		25		26	1.24	0.049	N/A	**5**	**18**	**7**	**30**	**1.24**	**1.34**	**0.060**	
42	**99284**		40		42	1.95	0.048	N/A	**5**	**25**	**10**	**40**	**1.95**	**2.56**	**0.089**	
43	**99285**		50		53	3.06	0.061	N/A	**8**	**40**	**15**	**63**	**3.06**	**3.80**	**0.082**	

RUC E/M Recommendations

	A	B	C	D	E	F	G	I	J	K	L	M	N	O	P	Q
1		Existing Data - RUC database						CPT	Workgroup Recommendations					RUC Recommendations		
2	Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Calc IWPUT	Time	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	Work RVU	IWPUT	
44	Critical care															
45	99291	15	45	15	75	3.99	0.074	30–74	15	40	20	75	4.29	4.29	0.088	Interim
46	99292		30		30	2.00	0.067	h addl 30		30		30	2.15	2.15	0.072	Interim
47																
48	Reference Codes															
49	45340	17	25	16	58	1.89	0.046									
50	60100	15	25	10	50	1.56	0.040									
51	76005	10	20	5	35	0.60	0.013									
52	90801	10	60	55	125	2.80	0.022									
53	90847	5	50	21	76	2.21	0.033									
54	90880	8	50	40	98	2.19	0.022									
55	93503	20	30	45	95	2.91	0.048									
56	95810	15	60	20	95	3.52	0.046									
57	95903	8	10	10	28	0.60	0.020									
58	97110	2	14	2	18	0.45	0.026									
59	99217	10	30	15	55	1.28	0.024									
60	99234	10	60	15	85	2.56	0.033									
61	99235	10	75	15	100	3.41	0.038									
62	99236				110	4.26										
63	99299	10	30	15	55	2.50	0.065									

RUC E/M Recommendations

	A	B	C	D	E	F	G	I	J	K	L	M	N	O	P	Q
1		Existing Data - RUC database						CPT	Workgroup Recommendations					RUC Recommendations		
2	Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Calc IWPUT	Time	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	Work RVU	IWPUT	
64	**Reference Codes**															
65	**99341**	6.5	20	10	36.5	1.01	0.032									
66	**99342**	10	30	12	52	1.52	0.034									
67	**99343**	15	50	17	82	2.27	0.031									
68	**99344**	15	60	25	100	3.03	0.036									
69	**99345**	15	90	30	135	3.78	0.031									
70	**99347**	5	15	10	30	0.76	0.028									
71	**99348**	9	30	10	49	1.26	0.028									
72	**99349**	10	40	15	65	2.02	0.037									
73	**99350**	15	72	20	107	3.03	0.031									
74	**99375**	10	32	15	57	1.73	0.037									
75	**99386**	5	40	10	55	1.88	0.039									
76	**99387**	5	45	10	60	2.06	0.038									
77	**99396**	5	30	10	45	1.53	0.040									
78	**99433**	3	15	2	20	0.62	0.034									

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE – YEAR REVIEW

CARDIOTHORACIC SURGERY

RUC RECOMMENDATIONS

Congenital Codes

The following congenital cardiac surgical codes 33414, 33416, 33505, 33665, 33684, 33688, 33771, 33779, and 33781 were reviewed. The RUC agreed that these codes should be reviewed because their current values represent rank order anomalies when compared with codes for similar surgical procedures. At the second Five - Year Review, many of the more common congenital cardiac surgical codes were reviewed, and of the values were adjusted. At that time these much less commonly performed codes were not surveyed due to resource and time constraints. The codes were reviewed for the current five-year review to correct the rank order anomalies.

The RUC felt that the codes presented were rank order anomalies in terms of the physician work relative value but during the review the RUC agreed that there were a number of reference procedures with inaccurate physician times. These codes were reviewed in the second five-year review and were assigned time based on cross walking the pre and post-service inputs to a reference procedure because it was felt that the survey times were inaccurate due to very low response rates. These response rates are attributable to these procedure being infrequently performed by a small number of surgeons. There were also codes with times collected in 1994 that had small sample sizes and may have been inaccurate. When these times were used to compare to the codes under review the RUC noted inconsistencies in all time segments, including intra-service time.

Therefore, the RUC suggested that the STS conduct a survey of time for these reference codes. The RUC agreed that these new five-year review values and times could not be used to justify changes in the relative values of the reference services. For example, there are three codes for artioventricular valve repair and 33665 *Repair of intermediate or transitional atrioventricular canal, with or without atrioventricular valve repair* is in the middle in terms of physician work and therefore needs to have an RVU lower than reference code 33670 *Repair of complete atrioventricular canal, with or without prosthetic valve* (work RVU= 34.95) but valued higher than 33660 *Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair* (work RVU = 29.96). The median survey value of 32.98 for 33665 appropriately places the code in proper rank order. However, the RUC examined the times for these two reference procedures and concluded that while the work

values were appropriate the times were inconsistent in comparison to the new time data for 33665. The preservice time of 45 minutes for these reference codes was low compared to the 100 minutes assigned to 33665. In addition the RUC felt that in intra-service time of 270 minutes for the reference code 33670 may be too high in comparison to code 33665 which has an intraservice time of 200 minutes. The presenter agreed that the times for the reference codes may be inaccurate.

The RUC recommends that the specialty conduct new surveys for codes 33660, 33670, 33506, 33770, and 33780 for physician time only.

Compelling Evidence for Adult Cardiac and General Thoracic

The STS presenters summarized the compelling evidence for the adult cardiac and general thoracic codes focusing on data from the STS database that shows that the adult cardiac patient population has changed in the last five year review. The presenters provided the following data to the RUC:

1. Evidence of change in patient population, length of hospital stay, and physician time.
    a. 30 prospectively identified patient characteristics were examined for all patients in all codes submitted. Absolute and Percent change in the incidence of clinically important risk factors were submitted for each code and in aggregate for all codes. The STS presenters explained that there was a pattern of increasing patient risk from 1995-99 to 2000-04.
    b. Multivariable analysis has been used to measure the overall risk of the coronary bypass patient population for mortality, morbidity, prolonged ventilation, and prolonged length of stay. The overall risks combine the independent risk of age, gender, diabetes, CHF, cardiac ejection fraction, cerebrovascular disease and other individual risk factors, thus representing the combined effects of change in multiple risk factors as a single risk estimate.
    For coronary artery bypass patients, these combined features of patient risk were compared for 1995-99 (N=683,482) to 2000-4 (N=570,501) with the following results:

	1995-99	2000-04	Change
Morbidity or Mortality	12.1%	14.1%	+16%
Hospital Readmission	7.4%	9.0%	+22%
Prolonged Ventilation	5.1%	6.2%	+22%
Prolonged Length of Stay	4.5%	5.4%	+19%

2. The presenters provided data for the adult cardiac codes showing evidence of change in physician work due to length of hospital stay and physician time (intra-service time) compared to incorrect assumptions made in the previous valuation of services.
3. The adult cardiac and general thoracic codes had inconsistencies between current valuation of codes (rank-order anomaly) or between supporting data and the current value of codes (flawed methodology).
4. Evidence of unrepresented physician work in the ZZZ codes due to change in methodology since their valuation.
5. Never undergoing review by the RUC and within a family meeting one or more of the other criteria.

The RUC considered evaluating the compelling evidence on a code by code basis but instead determined that since the RUC already approved the STS building block methodology, the RUC would not examine the compelling evidence for each code. Rather the RUC accepted the RUC approval of the STS methodology as the compelling evidence to examine each code. The RUC did review in detail the STS building block inputs for each code and made a number of changes in the inputs to arrive at new relative value recommendations. The specific changes the RUC made to the inputs are described later in this report.

Adult Cardiac

The STS submitted 46 Adult Cardiac CPT codes for review (38 - 090 Global codes and 8 - ZZZ Add-on codes). The STS used the RUC approved building block methodology utilizing the STS database. This database currently contains 2,208,649 (1995-2004) patient records collected from more than 450 practices, and provides a representative sample of geographic practice location and practice type. Over 70% of the hospitals currently performing heart surgery in the U.S. participate in this database. The STS used the RUC approved mean intra-service time for the adult cardiac codes due to the large sample sizes.

The STS national database was queried for prospectively collected data to provide objective information on patient characteristics, operative characteristics and perioperative management characteristics that constitute the basic components of physician work. Patients whose operative data could be unequivocally matched to unique CPT codes were analyzed for the time intervals 1995-1999 (prior to 2nd 5 year review, N=946,470) and 2000-2004 (post 2nd 5 year review, N=664,436) for a total of 1,610,906 patients. Patients were excluded if they had undergone multiple procedures, to ensure that intra-operative time and other patient data could be attributed purely to the CPT code under evaluation. Add-on codes 33141, 33517-33523 and 33530 were evaluated by subtraction of data of the base code patients from data of the combined base and add-on code, with the results weighted for frequency of occurrence.

Representative data were selected from over 200 variables specifying patient risk factors, hospital resource utilization, operative duration, length of intensive care unit stay, duration of mechanical ventilation, overall length of hospitalization, and the development

of postoperative complications. For some procedures, multivariable predictive algorithms were generated to distill patient risk for adverse events (prolonged length of stay, morbidity or mortality). Typical patients were described through combinations of allowed risk factors and age to describe 50% plus 1 of each code patient population. Additional patient profiles regarding the elements of postoperative care delivered were developed from the complication and resource utilization data for each code.

CPT codes 33411, 33413, 33460, and 33463 are low volume codes, and STS database data were supplemented with operative log and hospital record information on intraservice time, length of stay, gender, age, and ICU length of stay for 613 cases. These data were obtained from 50 practices that represented a range of practice type and location.

CPT code 35820 (Return to the Operating Room for Bleeding or Other Complication) was observed 18,275 times in the period 2000-2004 but its intraservice time was not recorded separately from the time recorded for the original procedure. STS data were supplemented from the same source with the addition of 667 cases with intraservice time determined directly.

General Thoracic

The presenters made a case for the existence of rank order anomalies in general thoracic codes, primarily due to the results from the last five-year review. At that time, the STS had nominated 31 codes for refinement. During RUC review, all but three of the recommendations for general thoracic codes were denied due to a lack of "compelling evidence." The society requested that at least three of the general thoracic codes be extracted from the consent calendar. The RUC allowed the STS to present additional data for three extracted general thoracic codes to determine if there was compelling evidence. Clinical data was obtained on several thousand patients documenting significant changes in patient profiles and upon review of the additional data, the RUC agreed that the data provided compelling evidence that the work had changed. The RUC allowed the specialty to bring recommendations for nine additional codes to the next RUC meeting for review.

The specialty realized that despite the fact that significant increases in work RVUs for the 12 refined codes would result in rank order anomalies, correction of such anomalies would have to wait until the 2005 Review. Thus several of the codes were proposed for review on the basis of rank order anomalies. These codes include:

1. Esophageal Resection codes

Of the12 codes refined in 2000, four (43107, 43112, 43117, 43122) dealt with four different operative approaches to resection of the esophagus and advancement of a gastric conduit as replacement. The survey demonstrated both increased age as well as an increased incidence of preoperative chemoradiation, a process known to make surgical dissection more difficult and perioperative morbidity

more likely. The RUC recommended increases for all four codes. All four of these esophageal resection codes described reconstruction using the stomach, the method widely considered to be the easiest and most expeditious. However, there remain 8 esophageal resection codes, resulting in widely disparate work values for codes involving similar work:

43108 Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)

43113 Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)

43116 Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction43112 (Total or near total esophagectomy, with thoracotomy; with cervical esophagogastrostomy

43118 Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)

43121 Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty

43123 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)

43124 Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy

43135 Diverticulectomy of hypopharynx or esophagus, with or without myotomy; thoracic approach

2. Lung Resection Codes

In the second Five- Year Review, several lung resection codes were refined (32440 pneumonectomy, 32480 lobectomy, 32482 bilobectomy, 32500 wedge resection). The RUC recommended increases in work RVUs for the lung resection procedures therefore creating rank order anomalies in the family of codes. These include:

32442 Removal of lung, total pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)

32445 Removal of lung, total pneumonectomy; extrapleural

32484 Removal of lung, other than total pneumonectomy; single segment (segmentectomy)

32486 Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)

32488 Removal of lung, other than total pneumonectomy; all remaining lung following previous removal of a portion of lung (completion pneumonectomy)

3. Decortication Codes

In the second Five - Year Review, two of the 12 codes accepted for refinement dealt with debridement of the pleural cavity and decortication (32220 decortication, pulmonary; total, 32320 decortication and parietal pleurectomy). The RUC increased the relative value for these codes but other codes in the family (those dealing with clearance of infected or sterile pleural contents) were not reviewed, thus crating a rank order anomaly. There remain debridement of the pleural cavity and decortication codes that were not revalued in 2000 and stand out as rank order anomalies. These include

32540 Extrapleural enucleation of empyema (empyemectomy)
32651 Thoracoscopy, surgical; with partial pulmonary decortication
32652 Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis
32653 Thoracoscopy, surgical, with removal of intrapleural foreign body or fibrin deposit

Methodology

The RUC reviewed the data elements for each code on a code by code basis. Most of the discussion focused on the number and level of post-operative visits as well as the pre-service time. For the adult cardiac and general thoracic codes the RUC agreed that the preservice time was overstated and needed to be more in line with previously approved RUC preservice times. Also, the RUC questioned the total times allocated to the codes when compared to a normal surgical work week. The RUC developed a pre-service time standard that was used for a majority of the codes. This standard was 60 minutes evaluation, 15 minutes positioning, and 20 minutes scrub dress and wait time. For emergent procedures, the pre-service times were set at 10 minutes evaluation, 12 minutes positioning, and 15 minutes scrub dress and wait time. The immediate post-service time was examined in conjunction with other visits on the same day of surgery. For most of the codes the immediate post-service time was standardized at 40 minutes.

The intra-service times were derived from the STS database with mean times used for the adult cardiac codes and median times for the general thoracic codes. Because the general thoracic code that have a much lower number of cases in the database, the STS felt that the median was more appropriate.

Critical care

For all of the adult cardiac codes and for 13 of the general thoracic codes, the presenters made a case that physician work equivalent to at least one critical care visit (99291) was provided by the operating surgeon. The RUC spent a great deal of time examining the work

performed by the operating surgeon and RUC agreed that a critical care visits should be used in the STS building block methodology. The presenters stated that the operating surgeon typically performs the work equivalent to the critical care codes.

In codes where the RUC assigned critical care, virtually all patients are initially managed in an Intensive Care Unit. The presenters provided the following description of the work involved. Patients have undergone an operation averaging 220 minutes of intra-service time, with 95 minutes of circulatory support with cardiopulmonary bypass, and an ischemic cardiac arrest time of 65 minutes. Recovery required an average of 16 hours of mechanical ventilation and an ICU stay of 53 hours. 43% of patients require the transfusion of blood or blood products.

The assignment of the level of critical care services was recommended for each code based on the STS expert panel's knowledge and experience in caring for these patients, within the framework of duration of mechanical ventilation and the length of ICU stay provided by appropriate data in the STS database. Typical critical care services involve evaluation, decision making and management of a highly complex nature due to:

- Multisystem recovery from anesthesia and the insult of cardiopulmonary bypass, with attendant systemic inflammation due to the activation of the complement system, alteration of the coagulation system, and prolonged exposure to high levels of endogenous and exogenous catecholamines.

- Recovery of cardiac function from the insult of ischemic arrest and injury, the precise nature of which depends on the specific cardiac procedure performed.

- Management of intravascular volume shifts related to systemic inflammation, warming, loss of vascular tone, changes in vascular permeability, and ongoing bleeding.

- The risk of postoperative bleeding, which is universal in cardiac surgical patients although variable in extent. The differentiation between coagulopathy and correctable surgical bleeding typically must be made on an ongoing basis in the first 6 hours following admission to the ICU. In addition, patients are at risk for tamponade which may be subtle and therefore may not manifest typical signs in the early post-operative period.

An example of a detailed description of critical care provided to the RUC for 33533 (Single vessel arterial coronary artery bypass graft) follows:

- Assess neurological state
  - Monitor emergence from anesthesia
  - Administer sedatives, paralyzing agents and analgesics as needed
  - Evaluate gross neurologic function including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present
  - Repeat evaluation until intraoperative neurologic injury is ruled out.
- Assess hemodynamic condition
  - Evaluate cardiac rhythm
    - Assess rate, conduction abnormalities
    - Consider temporary pacemaker
    - Initiate temporary pacing as needed. Determine suitable mode, adjust output and sensitivity of device. Repeat assessment of hemodynamic effects
    - Assess arrhythmias, differentiate atrial extrasytoles or runs from ventricular extrasystoles or runs, correlate with operative events and hemodynamic effects, consider antiarrhythmic therapy (treatment or prophylaxis)
    - Review 12-lead EKG for signs or ischemia or injury, compare to preoperative tracing
  - Assess blood pressure, central venous pressure, pulmonary artery pressures, cardiac output and index
    - Correlate pulmonary artery diastolic pressure, wedge pressure and CVP at baseline, confirm calibration of transducers with zero level at the level of the right heart, assess waveforms
    - Administer crystalloid fluids or blood products depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures
    - Adjust inotropic and vasoactive agents given by continuous infusion to optimize O2 delivery and minimize adverse end-organ effects
    - Carefully evaluate peripheral perfusion by observation and physical exam, correlating findings with invasive monitoring results
  - Monitor chest tube bleeding
    - Assess the character of the mediastinal drainage (rate, amount, tenacity, stability of clot)
    - Assess the patency of the mediastinal tubes, ensure that a cardiac tamponade state is avoided. Correlate bleeding quantity and character with chest x-ray, labs, hemodynamics, urine output and physical exam.
    - Assess laboratory results, correlate with other findings, and determine the need for blood, blood products including platelets cryoprecipitate and fresh frozen plasma

        - Consider other adjunctive pharmacologic therapies for coagulopathy
        - Consider need for re-exploration if chest tube output exceeds acceptable limits or if tamponade is present
- Respiratory System
    - Examine breath sounds, observe chest mechanics, assure mid-line tracheal position by physical exam
    - Assess ventilator settings, observe underlying respiratory pattern, observe baseline airway pressures generated and minute gas flow
    - Re-evaluate post-operative chest x-ray if necessary
        - Confirm endo-tracheal tube placement by review of post-operative chest x-ray
        - Monitor lungs for infiltrate/atalectasis
        - Assess pleural spaces for fluid collection
    - Assess blood gases and adjust ventilator as needed
    - Wean from ventilator
    - Assess readiness for extubation
    - Extubate patient and assure airway and adequacy of ventilation
- Assess adequacy of urine output
    - Check post-operative creatinine in light of pre-operative renal function
    - Assess volume status and administer fluids as needed
    - Decide if diuretic is indicated, determine dose, monitor response
    - Correlate urine flow with blood pressure compared to preop, assess interaction of cardiac output and vasoactive agents with renal function
- Monitor distal extremity perfusion
    - Assess peripheral pulses
    - Compare to preoperative findings
- Integrate comprehensive evaluation with patient history, expected status based on conduct of the operation, and response to critical care interventions. Assess extent of inflammatory state, consider treatment with antipyretics or steroids as indicated.
    - Review nursing/other staff patient chart notes
    - Discuss interval plans with nursing staff
    - Set parameters for interval adjustments in patient treatment
    - Establish interval to next patient evaluation if expected goals met

Post-Service Hospital Visits

The RUC made changes to the hospital visits on a line by line basis, but used the STS length of stay data as a guide. Generally the level of hospital vists were reduced but the total number of visits equaled the length of stay. On the day of discharge the RUC assigned a discharge day management code as the only service provided on that day.

For the adult cardiac codes the summary sheets listing the length of stay includes the day of discharge, but for the general thoracic data sheet, the length of stay does not include the discharge day due to differences in how the data was compiled, but the RUC used the same methodology for the adult cardiac and general thoracic codes.

IWPUT

IWPUT was estimated using two methods (IWPUT magnitude estimation and RASCH paired analysis) for each code. There were 533 cardiac surgery respondents, 168 completed the Intensity survey and 365 completed the Rasch survey. Each method used anchor codes familiar to thoracic surgeons. All anchor codes were previously RUC reviewed, none were submitted for refinement, and some were on the current MPC list.

According to the presenters, IWPUT magnitude estimation produced direct IWPUT values. RASCH analysis produced arbitrary scalar values as estimates of CPT code intensity rank and dispersion. These values were converted to IWPUT values by regression of the results to obtain slope, and offset of the results was based on the median value of the magnitude estimation survey. Each RASCH scalar was then converted to IWPUT with the familiar formula $y=mx+b$ where m is the slope and b is the y intercept.

The average IWPUT estimate for each code was presented and accepted by the RUC. The RUC did not make any changes to the IWPUT estimates provided by the presenters.

The RUC did examine the intensities assigned to each code and chose not to make any changes because it could have created rank order anomalies. Based on the two intensity surveys and the review by the STS expert panel, the presenters stressed that all of the intensities were in the proper rank order any changes could create anomalies. For example, the RUC discussed in detail several families of bypass add on codes, the RUC questioned the increasing intensities within the families (33510- 33516), (33517-33523), and (33533-33536). The presenters stated that as the number of grafts increases, the procedures changed in intensity due to a different patient population with additional comorbidities when compared to the base code and therefore justified incremental increases in intensity among the family of codes. In addition, for the add on codes these patient required additional post-service hospital care and the additional time spent in the ICU and in the hospital was identified for each of these codes. The presenters then multiplied this

additional time by a mean RVU per day of ICU care and non ICU care based on the average recommended RVU per day in the ICU and non ICU for the bypass base codes.

Building Block Methodology

The recommended total RVW for each code was developed by the building block method to sum the values of each interval of the 90 day global period for physician work. The values were determined utilizing STS data, survey results as described, and an expert panel. The expert panel was composed of 15 cardiac surgeons with geographic representation from the East, Northeast, West, Northwest, Midwest, and South and from an equal mix of private and academic practices. This methodology consists of the following:

1.	**Pre- Evaluation Time**	Each pre-service time component was developed by the Expert Panel after review of the allowed elements and review of each code individually.
	Pre- Positioning Time	
	Pre- Scrub, Dress, Wait Time	
2.	**Intra-Service Time**	STS database mean skin-to-skin times were accepted by the Expert Panel. The median intra-service times were used for the general thoracic codes due to the lower sample size.
3.	**IWPUT**	The Expert Panel reviewed the results of the two surveys, and selected the average of the two results as representative
4.	**Immed. Post-time**	Immediate post-time (after skin closure and through discharge from recovery) was developed by consensus of the Expert Panel after discussion of the allowed elements and review of each code individually.
5.	**Post -Critical Care Visits**	The STS database length of stay, ICU hours, and ventilator hours were utilized by the Expert Panel to assign one or more allowed E&M visit per day of the mean length of stay. Definitions of each allowed E&M service within hospital portion of the global period were reviewed, and a consensus recommendation for each code made.
	Post - Other Hospital Visits	
	Discharge Day Visit	
6.	**Office Visits**	The frequency and level of post-discharge office visits were developed by the Expert Panel after reviewing the definitions of each visit and considering each code individually.

For all of the 90 day global period adult cardiac and general thoracic specialty society argued that the current relative value is inappropriate due to a change in the patient population, and rank order anomalies in comparison with other cardiothoracic codes. The

presenters used a RUC approved building block methodology based on the STS adult cardiac database that provided a mean intraservice time for the adult cardiac codes and a median time for the general thoracic codes. The STS database also provided the length of stay. Two intensity surveys were conducted and the final recommended intensity is an average of the two survey results. The remaining pre-service and post-service inputs were derived through an expert panel process. The RUC reviewed each input and made a number of changes to standardize the pre-service times and to reduce the level of post operative hospital visits. The post operative office visits were not adjusted. The RUC recommended new relative values based on an analysis of the STS building block data.

Other Issues

- STS withdrew their level of interest for code 32020.
- The RUC accepted STS withdrawal of codes 32095 and 35600

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Recommendations – General Surgery/Colorectal Surgery/Vascular Surgery

Vascular Surgery

The Society for Vascular Surgery (SVS) in coordination with several other specialty societies including American Academy of Orthopaedic Surgeons, Society of Thoracic Surgeons and American Podiatric Medical Association expressed an interest in developing recommendations for 33 codes. Of the 33 codes, the SVS withdrew three codes from the Five Year Review. Of the remaining 30 codes a few were identified due to changes in technology that has changed physician work however, the majority of the codes were identified because of initial flawed assumptions made in the previous valuation of the service

The Society for Vascular Surgery (SVS) and the North American Chapter of the International Society for Cardiovascular Surgery (ISCVS) has commented on several occasions to the Health Care Financing Administration (CMS) that non-cardiac peripheral vascular surgical procedures have been systematically undervalued since the original Hsaio/Harvard studies. At each opportunity to comment on the Resource-Based Relative Value System (RBRVS), the SVS/ISCVS has argued that the representation and process utilized to evaluate vascular surgery was unfair. This undervaluation has an enormous impact on vascular surgery as 60-70% of all patients requiring peripheral vascular reconstruction belong to the Medicare population.

Following publication of the November 1991 Final Rule and the SVS/ISCVS public comment letter, CMS made modest adjustments to a small number of medium and high complexity vascular surgical procedures. The specialty had offered to review and realign all of the peripheral vascular codes, however, CMS announced that consideration of further broad-based adjustments would be deferred until the initial Five-Year Review.

On February 6, 1995, the SVS/ISCVS submitted a public comment letter to CMS, in response to CMS's request for comments on the initial Five-Year Review of the RBRVS. Although vascular surgeons contended that their specialty continued to be systematically undervalued, they requested a review of only nine specific vascular surgical procedures. The SVS/ISCVS understood that the RUC

and CMS preferred to review only a limited number of codes from each specialty in this initial Five-Year Review and this specialty wished to comply with these instructions. The RUC found the arguments presented by the SVS then (and detailed below) to be compelling. However, the RUC reviewed and recommended increases for only the specific vascular surgical procedures that were identified by the specialty for review.

On March 1, 2000, the SVS/ISCVS presented the same core arguments that they have expressed to CMS in previous comment letters. Unlike the previous Five-Year Review, vascular surgery argued that the majority (94 surgical procedures) of their services should be specifically reviewed on a code-by-code basis and to address their overall concern regarding the valuation of vascular surgery 10 years after the implementation of the RBRVS.

In all of the correspondence presented to CMS over the previous decade, the vascular surgeons have consistently presented the same arguments regarding their specific exclusion from the Harvard study. SVS/ISCVS reviewed the RUC's guidelines regarding compelling evidence, which are included in the RUC's *Instructions for Specialty Societies Developing Work Value Recommendations,* and addressed these guidelines in their comments as follows:

Proof that incorrect assumptions were made in the initial valuation of the service, as documented, for example, by a misleading vignette in the Harvard study, data from the study, and flawed crosswalk assumptions.

The physician work RVUs for more than 200 vascular surgery codes were extrapolated from surveys of only two peripheral vascular operations (infrarenal aortic aneurysm repair and carotid endarterectomy). The vascular surgeons have commented that inappropriate vignettes and flawed assumptions were made for the only two codes that were in fact directly surveyed. For example, the vignette in the Harvard study of abdominal aortic aneurysm recounted a healthy 65 year old male with a five centimeter aneurysm. However, most patients with abdominal aortic aneurysms (CPT codes 35081 and 35102) are older than 65, and virtually all have one or more comorbid conditions such as coronary artery disease, hypertension, or some compromise of kidney function.

Proof that the mechanism or methodology used in the original valuation was seriously flawed, for example, evidence that no pediatricians were consulted in assigning pediatric values.

Vascular surgeons were not including on the Phase I, II, or III Harvard technical consulting panels. The peripheral vascular codes were all grouped and evaluated with cardiac and general surgical procedures. The SVS or ISCVS were not asked to participate in this review. The actual vascular surgical experience of the surgeons who participated in these studies is unknown. However, the instructions given by Hsiao were for the surgeon evaluators to provide estimates of the time and intensity if the surgeon was "familiar" with the procedure, even if he or she didn't actually perform the procedure.

If Harvard surveyed one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to Medicare utilization data.

Clearly, Harvard utilized general and cardiac surgeons to determine work relative values for vascular surgical procedures. The SVS/ISCVS contends that Harvard researchers did not understand that vascular surgery is distinct from cardiothoracic surgery and, therefore, believed that these services were performed by cardiac surgeons. To further complicate the issue, Medicare claims data did not distinguish vascular surgery from general surgery until 1993. In reviewing the Medicare utilization data today, many claims that indicate that a "general surgeon" performed the procedure, are actual vascular surgeons that have not changed their specialty indication since this change was made by Medicare in the early 1990s.

An anomalous relationship between the code to be valued and multiple key reference services. For example, if code A describes a service that requires significantly more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay, and other factors for each of the other codes.

The vascular surgeons have commented that vascular surgical procedures are consistently undervalued in comparison to other surgical procedures and services included on the RUC's Multi-specialty Points of Comparison (MPC). A 1990 study by Abt Associates was commissioned to confirm these arguments. Internal committees and workgroups of the SVS have also collected evidence on intra-service time and intensity to compare their services to other services on the Medicare RBRVS. With referral of the broader issue of vascular surgery finally referred from CMS to the RUC to review in this Five-Year Review, the SVS/ISCVS employed several methodologies to provide compelling evidence that their services should be increased.

The SVS conducted standard RUC surveys and where data was available utilized an alternative methodology approved by the Research Subcommittee and the RUC. This alternative methodology is as follows:

The NSQIP was started by the VA for quality improvement purposes but now includes a large volume of surgical procedures from non-VA hospitals as well. The NSQIP database contains intra-service times and length of stay data. The ACS proposed a building block methodology that would use a consensus panel to assign pre service times, immediate post service times as well as IWPUT estimates. The intra-service times would be the median times from the NSQIP database. The NSQIP database length of stay will be used by the expert panel to develop number and level of hospital visits. The expert panel will also develop number and level of office visits based on comparisons to codes requiring similar physician work.

The RUC reviewed both the survey data and the NSQIP data where provided for each procedure. Overall, where the NSQIP time and length of stay data was available, the RUC felt that for these few procedures, the physicians responding to the survey underestimated their intra-service time and therefore the RUC felt that the NSQIP data more accurately reflected the intra-service times for these procedures. For the remaining procedures, the RUC reviewed the survey data and typically agreed with the survey median intra-service times and work with some notable exceptions where the RUC disagreed with these inputs as they felt did not reflect the service. In addition, the RUC, when reviewing these procedures, recommended standardized inputs for pre-service elements including 30 minutes of evaluation, 15 minutes of positioning and 15 minutes of scrub, dress and wait to most procedures unless otherwise specified.

Of the 30 codes, the RUC agrees with the specialty society and recommends referring nine codes to CPT. The RUC agrees with the specialty society that these codes cannot undergo the RUC evaluation process before having their descriptors revised to reflect a single operation rather than multiple or the code needs to be deleted. Of the remaining 21 codes, the RUC accepted 12 of the specialty society's recommendations to increase the existing RVUs. The RUC agreed with the specialty society that these procedures were undervalued due to compelling evidence such as changes in length of stay, changes in patient populations and incorrect assumptions made in the previous valuation of the service. The RUC increased nine codes, however, eight of these nine codes were increased below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued length of stay, changes in patient populations and incorrect assumptions made in the previous valuation of the service.

General Surgery

The American College of Surgeons (ACS) with several other specialty societies including Society of Interventional Radiology (SIR), American College of Radiology (ACR), American Society of (ASCoRS), and American Society of General Surgeons (ASGS) expressed an interest in developing recommendations for 40 codes. Of the 40 codes, ACS withdrew 8 codes from the Five Year Review. For the remaining 32 codes, 5 codes were identified by CMS for changes in technology and never been reviewed by the RUC. The remaining 27 codes were identified by the ACS' General Surgery Coding and Reimbursement Committee. This committee identified these codes by comparing various current physician work elements (pre-, intra-, post-times, number of visits in the global period and intensity) with data from previous reviews and refinements. The committee also looked for anomalies that may have been created by flawed assumptions from previous reviews.

The ACS conducted standard RUC surveys and where data was available utilized an alternative methodology approved by the Research Subcommittee and the RUC. This alternative methodology is as follows:

The NSQIP was started by the VA for quality improvement purposes but now includes a large volume of surgical procedures from non-VA hospitals as well. The NSQIP database contains intra-service times and length of stay data. The ACS proposed a building block methodology that would use a consensus panel to assign pre service times, immediate post service times as well as IWPUT estimates. The intra-service times would be the median times from the NSQIP database. The NSQIP database length of stay will be used by the expert panel to develop number and level of hospital visits. The expert panel will also develop number and level of office visits based on comparisons to codes requiring similar physician work.

The RUC reviewed both the survey data and the NSQIP data where provided for each procedure. Overall, the RUC agreed with the surveyed times with the feeling that the NSQIP data supported these times. Where the NSQIP time and length of stay data was recommended, the RUC felt that for these few procedures, the physicians responding to the survey underestimated their intra-service time and therefore the RUC felt that the NSQIP data more accurately reflected the intra-service times for these procedures. In addition, the RUC, when reviewing these procedures, recommended standardized inputs for pre-service elements including 30 minutes of evaluation, 15 minutes of positioning and 15 minutes of scrub, dress and wait to most procedures unless otherwise specified.

Of the 32 remaining codes under review, the RUC increased 28 codes, but below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued due to compelling evidence such as rank-order anomalies, changes in technology and incorrect assumptions made in the previous valuation of the service. The RUC maintained the existing RVUs for three codes because the RUC felt there was lack of compelling evidence to change the RVUs. The remaining code was referred to CPT due to the fact that the current descriptor results in two distinct patient populations and therefore needs to be separated into two codes to be appropriately valued.

Colon and Rectal Surgery

The American Society of Colon and Rectal Surgeons (ASCRS (colon)) with the American College of Surgeons expressed an interest in developing recommendations for 33 codes. Of the 33 codes, the ASCRS (colon) withdrew five codes from the Five Year Review. The remaining 28 codes were identified by the specialty society by comparing various physician work elements (pre-, intra-, and post-service time, number and level of visits in the global period and intensity) of colon and rectal surgery codes and other codes that have been reviewed by the RUC. These codes were identified based on flawed crosswalk assumptions, rank-order anomalies and changes in length of stay. For these 28 codes, a full RUC survey was utilized.

For the anal fistula and the rectal abscess family of codes the RUC reviewed the survey data and typically agreed with the survey median intra-service times and work with some notable exceptions where the RUC disagreed with these inputs as they felt did not reflect the service. In addition, the RUC, when reviewing these procedures, recommended standardized inputs for pre-service elements including 30 minutes of evaluation, 15 minutes of positioning and 15 minutes of scrub, dress and wait to most procedures unless otherwise specified. For the proctoscopy-anoscopy family of codes the RUC typically agreed with the survey median intra-service times with some notable exceptions where the workgroup disagreed with these inputs as they felt did not reflect the service. However, when assigning a work RVU to these procedures, the RUC recommended creating rank order by implementing an IWPUT analysis to ensure that services with similar intensities had similar IWPUTs. In addition, the RUC, when reviewing these procedures, recommended standardized inputs for pre-service elements including 20 minutes of evaluation, 10 minutes of positioning and 5 minutes of scrub, dress and wait to most procedures unless otherwise specified.

For the 28 codes presented, the RUC accepted five of the specialty society's recommendations to increase in existing RVU. The RUC agreed with the specialty society that these procedures are undervalued due to a flawed cross-walk assumption The RUC agreed with

the specialty society's recommendations to maintain three codes as the survey data supported the existing work associated with the code. The RUC increased 20 codes, but below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued due to rank-order anomalies.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW

OPHTHALMOLOGY AND OTOLARYNGOLOGY
RUC RECOMMENDATIONS

American Academy of Ophthalmology
The American Academy of Ophthalmology (AAO) with the American Optometric Association (AOA) and American Society of Cataract and Refractive Surgery (ASCRS) commented on 15 codes in the Five-Year Review for revision. CMS requested that fourteen ophthalmology codes be reviewed at the 2005 Five-Year Review. Of the twenty-nine codes submitted to this Five-Year Review, the specialty societies requested that the work RVU increase for 13 codes, decrease for one code, the current value be maintained for 11 codes and 4 codes be withdrawn.

CMS requested that the RUC review 14 ophthalmology codes. CMS selected 12 codes 66761, 67038, 67221, 67228, 67820, 67840, 68840, 76519, 92083, 92226, 92235 and 92250 to be reviewed because these procedures have never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information). In response to these 12 submitted codes, the RUC's recommendations are:

- The RUC did not support an increase in the existing value for code 92083 as it was agreed that the specialty had not presented compelling evidence that the physician work had changed.
- The RUC agreed with AAO that the work had not changed for codes 66761, 67840, 68840, 76519, 92226, 92235 and 92259, which is justified by the survey.
- The RUC referred codes 67038 and 67228 to CPT to specify how many membranes are stripped in 67038 and how many sessions apply to code 67228. The survey data may be flawed because respondents may have based their answers on a different number of membranes stripped or sessions conducted. Due to the inaccurate survey results the RUC could not value these procedures.
- The RUC did not support AAO's recommendation to maintain code 67221. This procedure did not have previous survey data or Harvard data. The RUC used a building block approach to support a decrease in the work RVU.

- The RUC supported AAO's recommendation to decrease the work value for 67820. The RUC recognized sufficient evidence that the previous Harvard survey data was flawed. The decrease in work value for 67820 was crosswalked to the key reference service code 65205.

CMS selected two ophthalmology codes, 66821 and 66984, for review because both of these procedures have experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish each procedure.

- AAO presented code 66821 *After cataract laser surgery*, which the RUC recognized that the intensity of this procedure was misvalued and an increase in the relative value would be appropriate. The RUC disagreed with CMS' previous intensity crosswalk to code 66984 specified in the May 3, 1996 proposed rule. The RUC recommends the 1995 RUC work RVU recommendation of 2.78. The RUC believes that the previous survey should stand on its own due to the inappropriate selection of intensity for this code.
- AAO presented code 66984 *Cataract surgery with intraocular lens prosthesis one stage*, which the RUC recognized that there has been increased efficiencies gained by technology and technique in the last ten years. The RUC believed that the work RVU was between the surveyed 25th percentile and the median, but closer to the 25th percentile. The RUC recognized efficiencies in pre-, intra-and post-service times, resulting in a lower overall time for the procedure. The RUC believed a lower value could be supported by a building block approach. The RUC took the previous survey pre-service time of 44 minutes, minus the current survey pre-service time of 25 minutes totaling 19 minutes. These 19 minutes were then multiplied by an IWPUT of .0224, resulting in an RVU of 0.43, which was subtracted from the current value. The RUC recognized that although the intra-service physician time has decreased from the historical 50 minutes to the current 30 minutes as indicated by the survey respondents, the decrease in time reflects a decrease of low intensity work (ie, suturing). What have been eliminated are the time consuming, but technically less difficult, portions of the procedure, especially wound creation and closure. What remains is the higher intensity work of removing the cataract and implanting the lens.

AAO requested that the RUC review 15 ophthalmology codes.

- AAO withdrew 5 codes from the Five-Year Review: 65420, 65900, 67917, 67924 and 68750.
- AAO presented 8 codes, which the RUC recognized that there was compelling evidence to support the recommended increases due to rank order anomalies, misvalued previous Harvard survey data when compared to codes with similar values and a change in the technique of performing the procedures (specifically for 67911 and 67966, in which skin-grafting is bundled in these codes).

- AAO presented 2 codes, 65426 *Removal of eye lesion* and 65850 *Incision of eye*, which the RUC recognized that there was compelling evidence to support increases, however not the specific increases recommended by AAO. For code 65426, evidence suggests a change in technique for this procedure, thus affecting physician work. The RUC felt that a value close to the survey 25th percentile was justified by using a building block approach. For code 65820, evidence suggests a rank order anomaly exists between 65820 and 66170, as well as a change in the patient population. The RUC justified an increase in value was justified by using a building block approach.

American Academy of Otolaryngology – Head and Neck Surgery and the American Head and Neck Society

The American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) presented 4 codes brought forth by CMS to the Five-year Review for revisions, along with one code in which AAO-HNS worked with the American Dental Association/American Academy of Oral and Maxillofacial Surgery (ADA/AAOMS) and the American Head and Neck Society brought forth 30 codes. CMS initially requested that six otolaryngology codes be reviewed at the 2005 Five-Year Review but then withdrew one code (31255). Of the thirty-four codes brought to the Five-Year Review, the specialty societies requested that the work RVU increase for thirty-three codes, decrease for one code.

CMS requested that the RUC review codes 30520, 31575, 31579, 41100 and 69210 because these procedures have never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).

- AAO-HNS presented code 30520, which the RUC recognized the additional work involved which was not captured previously due to flawed Harvard methodology. The RUC justified the RVU increase by using a building block methodology.
- AAO-HNS presented code 31575 and 31579, which the RUC agreed that the surveys validate the current values. The RUC recommends maintaining the original work values.
- AAOMS and AAO-HNS presented code 41100, which the RUC failed to recognize compelling evidence to justify a decrease in the relative value for this service. The RUC recommends to maintain the current value of this service, which the RUC felt was justified by the survey in which 98% of respondents indicated that the work in performing this service has not changed in the past five years.
- AAO-HNS presented code 69210, which the RUC did not agree with the specialty society that the patient population has changed to a more complex population for code 69210. The RUC recommends to maintain the current value of this service, which the RUC felt was justified by the survey in which 94% of respondents indicated that the work in performing this service has not changed in the past five years.

AHNS requested that the RUC review the palate resection, maxillectomy, lympadendectomy, pharyngectomy, tonsillectomy, glossectomy, laryngopharyngectomy and laryngectomy codes due to flawed Harvard methodology, rank order anomalies, a change in patient population or simply the code has not been reviewed by the RUC. Some of the codes showed a flaw in previous methodology because the previous valuation was based on general surgeons instead of otolaryngologists whom have been the primary provider of these services since at least 1993. AHNS also believed that the Harvard data was flawed because it refined some codes in the Harvard Phase 4 but did not for others in that family nor was the pre- and post-service work surveyed, thus causing rank order anomalies. Additionally, the patient population has changed since 1995, specifically for the pharyngectomy codes (42890, 42892 and 42894), the laryngopharyngectomy codes (31360, 31365, 31390 and 31395), and the laryngectomy codes (31367, 31368, 31370, 31375, 31380, 31382). Many patients today are either not candidates for chemo-radiation therapy because of advanced disease or have failed chemo-radiation therapy.

Of the 29 procedures that AHNS recommended, all were recommendations for increases in the work value. The 29 procedures that AHNS recommended were grouped into 10 categories: Palate Resection, Maxillectomy, Lymphadendectomy, Pharyngectomy, Tonsillectomy, Glossectomy-partial, Glossectomy-complete, Glossectomy-composite, Laryngopharyngectomy and Laryngectomy. Summaries of the RUC recommendations, in which the full RUC survey was utilized for these procedures, are shown below.

- AHNS presented 1 Palate Resection procedure, which the RUC recognized the increased work and intensity involved in comparison to other codes with similar intensity. The RUC believed the survey results reflected the complexity of the patient, physician time and work necessary in performing this procedure.
- AHNS presented 2 Maxillectomy procedures in which the RUC viewed as undervalued. The reevaluation of these two codes corrects rank order anomalies and accounts for the appropriate intensity for each procedure.
- AHNS presented 3 Lymphadenectomy procedures, which had a flawed previous valuation because the procedures were not evaluated by otolaryngologists. The RUC recognized believed that the survey results reflected the appropriate complexity of the patient, physician time and work necessary in performing the procedure and justified an increase in physician work.
- AHNS presented 3 Pharyngectomy procedures, which had never been reviewed by the RUC. The RUC recognized a change in the patient population and the increased intensity involved in these procedures compared to other codes with similar intensity. The RUC recommended the increase demonstrated by the survey median.
- AHNS presented 3 Radical Tonsillectomy procedures, which the RUC recognized as being undervalued due to previous flawed methodology. The RUC believed that the survey results reflected the appropriate physician work and time necessary in performing this procedure.

- AHNS presented 3 Glossectomy-partial procedures, one of which the RUC felt that there was not compelling evidence presented to increase the work, therefore the RUC recommends maintaining the value for 41120. The RUC recognized that by increasing the values for the two remaining procedures, specific rank order anomalies would be corrected and could be justified by survey results.
- AHNS presented 2 Glossectomy-complete procedures, one of which the RUC could not justify decreasing. Over half of the survey respondents indicated that work of performing 41140 has not changed in the past five years and the RUC recommends maintaining the value for this code. The RUC did believe that previous flawed methodology for code 41145 caused this procedure to be misvalued and an increase in work is validated by the survey median results.
- AHNS presented 3 Glossectomy-composite procedures each of which create rank order anomalies. The RUC recognized that by increasing the RVUs of these three procedures, specific rank order anomalies would be corrected and could be justified by survey results.
- AHNS presented 4 Laryngopharyngectomy procedures each of which create rank order anomalies and have experienced a change in patient population. The RUC recognized that by increasing the RVUs of these procedures and accepting the 75th percentile of survey results the specific rank order anomalies are corrected and the change in patient population is accounted.
- AHNS presented 6 Laryngectomy procedures each of which create rank order anomalies due to previous flawed methodologies and have experienced a change in patient population. The RUC justifies the RVU increase in code 31367 by using a building block methodology and corrects rank order anomalies and the change in patient population by recommending the survey physician work 75th percentiles.