AMA/Specialty RVS Update Committee
April 27-30, 2000

The Knickerbocker Hotel
Chicago, Illinois

I. **Call to Order:**

Doctor James G. Hoehn called the meeting to order on Thursday, April 27, 2000 at 2:23 p.m. The following RUC members were in attendance:

James G. Hoehn, MD, Chair
Joel Bradley, MD
James Blankenship, MD
Lee Eisenberg, MD
Robert Florin, MD
John Gage, MD
William Gee, MD
Alexander Hannenberg, MD
W. Benson Harer, MD
James Hayes, MD
Richard J. Haynes, MD
David Hitzeman, MD
Charles Koopmann Jr., MD
Barbara Levy, MD
J. Leonard Lichtenfeld, MD
James Maloney, MD*
David L. Massanari, MD
John Mayer, MD
David L. McCaffree, MD
James Moorefield, MD
Bill Moran, MD
Alan L. Plummer, MD
Greg Przyblski, MD
David Regan, MD
William Rich, MD
Peter Sawchuk, MD*
Ronald Shellow, MD*
Paul Schnur, MD
Bruce Sigsbee, MD
Sheldon Taubman, MD
Trexer Topping, MD*
Laura Tosi, MD*
Richard Whitten, MD*
Don E. Williamson, OD
Robert Zwolak, MD

* Alternate RUC Member

II. **Chair's Report:**

Doctor Hoehn welcomed RUC members and announced the following changes and re-appointments to the RUC composition:

- Doctor Bill Moran as new chair of the Practice Expense Advisory Committee (PEAC).
- Doctor Hoehn announced the retirement of Doctor W. Benson Harer. On behalf of the RUC, Doctor Hoehn presented Doctor Harer with a token of appreciation and expressed the RUC's gratitude for the many years of personal commitment to the RUC process.
- Doctor Hoehn informed the RUC that Doctor William Winters sent a note that indicated his appreciation for the opportunity to participate in the RUC process. Doctor Winter's term concluded with the February 2000 RUC meeting.

Doctor Hoehn announced new appointments and re-appointments to the RUC which are as follows:

1) Doctor Joel Bradley
2) Doctor William Gee
3) Doctor Alexander Hannenberg
4) Doctor Richard J Haynes
5) Doctor Charles F. Koopmann, Jr.
6) Doctor Barbara S. Levy
7) Doctor David Massanari
8) Doctor John E. Mayer, Jr.
9) Doctor David L. McCaffree
10) Doctor William Rich
11) Doctor Bruce Sigsbee

Doctor Hoehn informed RUC members about the American Medical Association's realignment and announced that the RUC staff will now report to the Advocacy Group at the AMA.

Doctor Hoehn introduced Jim Rodgers PhD, Vice President of Health Policy. Dr. Rodgers explained that the AMA's organizational changes should not directly affect the RUC's operations. Dr. Rodgers stated that the AMA continues to view the RUC as a successful cooperative arrangement and will continue to provide financial and staff support to the process.

Dr. Rodgers informed RUC members about the discontinuation of the SMS survey in its current format. He explained that it has become increasingly difficult to administer the survey as physician responses are difficult to obtain and the costs have increased tremendously. He announced that the AMA has formed an internal workgroup to consider new options in collecting and/or obtaining this data. RUC members expressed serious concern regarding the discontinuation of the SMS survey. RUC members indicated that the survey was the only data collected that has been accepted by HCFA and voiced concern regarding the need to collect future data to refine practice expense relative values. Dr. Rodgers agreed to provide periodic updates on the AMA's activities regarding future data collection.

Doctor Hoehn announced that he had approved the American Burn Association and the American Society of Transplant Surgeons request to appoint a member to the RUC's Advisory Committee.

Doctor Hoehn requested that as there is a great amount of work to accomplish, presenters should confine their comments to five minutes. Doctor Hoehn explained that during the discussion phase, he will call upon assigned RUC members to help facilitate the presentation and that open discussion will be limited to two minutes per individual.

Doctor Hoehn announced the Facilitation Committees:

Facilitation Committee 1	Facilitation Committee 2
David Hitzeman, DO (Chair)	W. Benson Harer, MD (Chair)
Robert Florin, MD	John Gage, MD
Alexander Hannenberg, MD	Charles Koopmann, MD
John E. Mayer, MD	David McCaffree, MD
William Rich, MD	David Regan, MD
Bruce Sigsbee, MD	Sheldon Taubman, MD
Sherry Barron-Seabrook, MD (Advisor)	Sandra Reed, MD (Advisor)
James Georgoulakis, PhD (HCPAC)	Marc Lenet, DPM (HCPAC)

Facilitation Committee 3	Facilitation Committee 4
Peter Sawchuck, MD (Chair)	Joel Bradley, MD (Chair)
James Regan, MD	Richard Haynes, MD
J. Leonard Lichtenfeld, MD	David Massanari, MD
James Moorefield, MD	Alan Plummer, MD
Ronald Shellow, MD	Paul Schnur, MD
Robert Zwolak, MD	Richard Whitten, MD
Karl Becker, MD (Advisor)	John Derr, MD (Advisor)
Samuel Brown, PT (HCPAC)	Nelda Spyres, LCSW (HCPAC)

III. **Director's Report**

Sherry Smith presented the Director's Report to the RUC members. Sherry Smith informed RUC members that an updated meeting schedule was placed in Tab 2 of the RUC Agenda Book.

Upcoming RUC meetings include:

August 24-27, 2000	Swissotel, Chicago, Illinois
October 5-8, 2000	Westin O'Hare, Chicago, Illinois
February 1-4, 2001	The Pointe Hilton at Tapatio Cliffs, Phoenix, Arizona

IV. Approval of Minutes for the February RUC meeting

The RUC approved the February 2000 minutes without modification.

V. **CPT Update**

Doctor Lee Eisenberg, CPT representative to the RUC, presented the CPT update to the RUC members. Doctor Eisenberg announced that CPT is beginning the 2002 cycle with the May 2000 Panel meeting. Doctor Eisenberg then provided a brief update on CPT-5 including implementation of the new tracking codes to describe new technology and performance measurements. Doctor Eisenberg also announced that CPT will place new 2001 immunization codes on the website to facilitate the usage and reporting of these codes in advance of their publication of the CPT 2001 book.

VI. **Health Care Financing Administration (HCFA) Update**

Doctors Paul Rudolf and Tom Marciniak presented the HCFA update to the RUC members on the following issues:

- Doctor Rudolf informed RUC members that HCFA will present to the CPT Editorial Panel proposed revisions to the Critical Care guidelines at the May 2000 Panel meeting.
- Doctor Rudolf indicated that the Carrier Medical Directors (CMD) will be attending the Five-Year Workgroup meetings and Doctor Rudolf hopes this will facilitate the CMD's understanding of these codes and assist in HCFA's review of the RUC recommendations.
- Regarding the Five-year review, Doctor Rudolf informed RUC members that HCFA is still continuing to research physician time. HCFA is currently completing two studies. The first is a review of DJ Sullivan operating room time to make direct comparisons to intra-time for major surgical services. The second pilot study has reviewed inpatient and outpatient records for general surgical services to validate the number and level of visits currently captured in the RUC and Harvard data. Doctor Rudolf will present the results of this study at a future RUC meeting.
- Doctor Tom Marciniak commented on the PEAC meeting and that Doctor William Moran, the new PEAC chair ran a successful meeting. Doctor Marciniak informed RUC members that the Final Rule on Outpatient Prospective Payment System was published on April 7, 2000 and explained that the deadline for public comments is June.
- Regarding CPT issues, Doctor Marciniak stated that ocular photodynamic therapy had recently been identified as an issue that needs to be addressed. The descriptor of this new technology was added to CPT code 67220 in year 2000 and the CPT Editorial Panel indicated that this was an editorial change; and therefore would not go through the RUC process. Doctor Marciniak explained that the work, however, is much different and the action was <u>not</u> editorial. In fact, he estimated that overpayment for this service could potentially reduce overall physician payment via the Sustained Growth Rate (SGR), by a total of 1%. In response, Doctor Eisenberg explained that the CPT Editorial Panel made the decision based upon the advice of the individuals proposing the coding change, who deemed this issue to be an editorial revision. Grace Kotowicz further explained that the proposal contained a request for a new code; however, after Advisor review it was determined that the procedure should be included in the existing CPT code and that a new code should not be created. AMA staff suggested that the RUC might wish to review a listing of proposed "editorial" changes in the future to provide additional advice regarding whether a coding change is indeed editorial.

VII. **Washington Update**

Sharon Mcllrath from the AMA's Washington office reviewed a number of legislative and regulatory initiatives.

On the Legislative side:

- The conference on Patient Bills of Rights is still convening. The key remaining issues still to be resolved are the scope of the Bill of Rights, the resistance of the Senate regarding accountability and reliability.
- The House Judiciary Committee approved the Campbell Bill in March, which will permit physicians to work together in negotiations with managed care plans. Included is an amendment that would cause this to sunset after three years and calls for an FTC study to help determine if it should continue.
- The House passed a Pain Relief Act of 1999 bill last fall.
- Medicare reform is still being addressed.

On the Regulatory Side:

- Congress told HCFA to develop a new SGR for calendar year 2000. This would permit spending to increase by 5.8% compared to the 2.1% in the earlier calculation. HCFA has estimated that this will result in a 1.8% update next year.
- A final rule on the Outpatient Prospective Payment System was published earlier in April 2000 and will be open for comment on several new features that are required under the Balanced Budget Refinement Act (BBRA). This system creates groups of services and then reimburses the same amount for every service in that group. Implementation is set for July 1.
- HCFA intends to expand the process in its campaign regarding Fraud and Abuse and enrollment form. As a result, all physicians will have to fill out a new enrollment form. The information on this form would have to be revalidated every 3 years.
- Health and Human Services Office of Civil Rights issued a proposed rule that would require physicians' offices to provide interpreters for non-English speaking patients.

VIII. Relative Value Recommendations

Chemodenervation of Muscles of the Trunk and the Limbs (TAB 5)
Presenters: James Anthony, MD and Richard Harvey, MD
Reviewed by Facilitation Committee 1

New CPT code 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* was created to describe injection of botulinum toxin into the limb and trunk muscle(s) for treatment of dystonia, spasticity, cerebral palsy, multiple sclerosis and muscle spasms. Botox is a neurotoxin that irreversibly blocks acetocholine, which results in partial paralysis of the muscles. Typically, for vocal dystonia the physician targets two muscles for injection in which EMG localization is used to identify the muscles. The physician typically targets four to eight muscles for injection in a limb. CPT currently contains codes for chemodenervation for muscles of the face and neck; however, CPT does not contain a code that accurately describes chemodenervation of the trunk and/or limb muscles.

The RUC did not accept the initial specialty society work value recommendation for new code 64614. Facilitation Committee One reviewed this issue and presented the following recommendation to the RUC.

The intensity of work for new code 64614 is greater than the reference service code 64613 *Destruction by neurolytic agent (chemodenervation of muscle endplate); cervical spinal muscles (eg, for spasmodic torticollis)* (work RVU = 1.96), as the muscles to be injected are not easily determinable and there are a greater number of injections performed in the trunk and/or limb muscles. Also, the dosage of botox given is substantially higher in new code 64614 than compared to the reference service code. The RUC noted that this procedure is more difficult and involves more work, as the typical patient is either a stroke or cerebral palsy patient. Additionally, this procedure involves injections into 4-8 muscles whereas the reference service code typically involves injections into less than 4 muscles. The RUC also compared code 64614 to 67345 *Chemodenervation of extraocular muscle* (work RVU = 2.96). The RUC agreed that 2.20 is appropriate as it reflects increased work over codes 64612 and 64613.

The RUC recommends a work relative value of 2.20 for CPT code 64614.

CPT codes 64612 *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)* and 64613 *Chemodenervation of muscle(s); cervical spinal muscle(s) (eg, for spasmodic torticollis)* were revised; however, the RUC does not recommend a change in the work relative values.

Practice Expense Recommendations
The RUC agreed that the list of practice expenses accurately reflected the resources required to perform the procedure in the non-facility setting. There are no direct practice expense inputs when performed in a facility setting.

<u>Cryosurgical Ablation of the Prostate (TAB 6)</u>
Presenter: **James B. Regan, MD**
Reviewed By Facilitation Committee 2

New CPT code 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)* describes cryosurgical ablation of the prostate due to prostate cancer. Cryosurgical ablation of the prostate consists of freezing a cancerous prostate causing cell destruction and death. New code 55873 includes placement of a suprapubic tube, which is included in the work of 55873 and not separately reported. Currently, this procedure is reported using the unlisted code 55899 *Unlisted procedure, male genital system*, as CPT does not contain a code that accurately describes this service.

The RUC did not accept the initial specialty society work value recommendation for new code 55873. A Facilitation Committee reviewed this issue and presented the following recommendation to the RUC.

The time and intensity and complexity measures for new code 55873 were compared to the original reference service code 55845 *Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes* (work RVU = 28.55).

However, the RUC agreed the work of new code 55873 was more comparable to the work and time described by code 55801 *Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)* (work RVU = 17.80) with the ultrasonic guidance component included in code 55873. The total physician time of 395 minutes for code 55873 is comparable to the total physician for 55801 of 461 minutes.

The RUC recommends a work relative value of 17.80 for code 55873.

Practice Expense Recommendations
The RUC recommends that the pre-service clinical staff time be reduced from 89 minutes to 45 minutes (for RN/LPN) to be consistent with other codes in the family. The RUC recommends approval of all other practice expense inputs for this service as presented. This service is performed in a facility setting.

76967
The RUC recommended that the CPT Editorial Panel reconsider its action to create a separate code for ultrasonic guidance for interstitial cryosurgical probe placement, as this service is an inherent component of the cryosurgical ablation of the prostate, code 55873.

The CPT Editorial Panel subsequently rescinded its earlier action to create this code and bundled this service into the primary procedure.

Reversal of Sling Operation for Stress Incontinence (TAB 7)
Presenters: James B. Regan, MD, Sandra Reed, MD
Reviewed by Facilitation Committee 2

New CPT code 57287 *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)* describes the removal or revision of a sling due to infection, graft erosion or persistent urinary retention. Currently, CPT does not contain an existing code that accurately describes this service; therefore, this service was reported using the unlisted code 58999 *Unlisted procedure, female genital system (nonobstetrical)*.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

New code 57287 was originally compared to the reference service code 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 13.02); however the RUC determined the work to be more comparable to code 51840 *Anterior vesicourethropexy, or urethropexy (Marshall-Marchetti-Krantz, Burch); simple* (work RVU = 10.71) and accordingly recommends a work relative value of 10.71. The RUC noted that the Harvard intra-service time for code 51840 is 74 minutes, which the RUC agreed to be more comparable to the 70 minutes of intra-service time for new code 57287.

The RUC recommends a work relative value of 10.71 for code 57287.

Practice Expense Recommendation
The practice expense inputs for 57287 were crosswalked from existing inputs for CPT code 51845 *Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)*. The RUC approved the practice expense inputs for 57287 with the following recommended changes:

- Syringe with water be modified to be supply code 91407 Syringe, 10cc – 12cc.
- The staff type was changed from RN only to RN/LPN
- Staple removal kit removed from medical supplies
- Ultrasound removed from overhead medical equipment

This service is provided in a facility setting.

Endometrial Ablation (TAB 8)
Presenters: George Hill, MD and Sandra Reed, MD

New CPT code 58353 *Endometrial ablation, thermal, without hysteroscopic guidance* was created to describe the use of thermal energy to ablate uterine tissue. Currently, this procedure is reported using code 58563 *Hysteroscopy, surgical; with endometrial ablation (any method)* (work RVU = 6.17) with the modifier –52 (Reduced Services) appended. However, the existing code 58563 describes the procedure performed via a hysteroscope whereas the service described by new code 58353 is performed without using a hysteroscope.

The RUC agreed the physician work for new code 58353 (work RVU = 3.56) was not comparable to the original reference service code 58563 *Hysteroscopy, surgical; with endometrial ablation (any method)* (work RVU = 6.17). The RUC determined that it would be appropriate to subtract the work of a diagnostic hysteroscopy, code 58555 *Hysteroscopy, diagnostic (separate procedure)* (work RVU = 3.33) from the hysteroscopic endometrial ablation code 58563 (work RVU = 6.17), to yield a work relative value of 2.84. However, this value did not reflect the work inherent in dilating the cervix, sounding the uterus and inserting the balloon device. The RUC determined this work to be comparable to that of inserting an intrauterine device, code 58300 *Insertion of intrauterine device (IUD)* (work RVU = 1.01). The RUC added in the work of 58300 (work RVU = 1.01) to 2.84 to obtain a total work relative value of 3.85. This was similar to the survey 25th percentile work RVU = 3.56, which was also the recommended specialty society work value; therefore, the RUC agreed that 3.56 was an acceptable work value.

The RUC recommends a work relative value of 3.56 for code 58353.

Practice Expense Recommendations
The RUC approved the direct practice expense inputs. These inputs were originally developed by the specialty's consensus Panel and standard supply packages were applied to this code. The RUC removed the autoclave from the overhead equipment category. This service is performed in a facility setting.

Incision and Drainage of Vaginal Hematoma (TAB 9)
Presenters: George Hill, MD and Sandra Reed, MD

New CPT code *57022 Incision and drainage of vaginal hematoma; post-obstetrical* describes the procedure of incising and draining a vaginal hematoma. Vaginal hematomas may occur as a complication of delivery, vaginal surgery and as a result of accidents. Typically, this procedure is performed on obstetrical patients in the global

obstetrical period; however, this procedure requires a return trip to the operating room and therefore, is not considered to be included in the global obstetrical package. This service is also typically performed on an urgent basis. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted codes 58999 *Unlisted procedure, female genital system (nonobstetrical)* or 59899 *Unlisted procedure, maternity care and delivery* were reported.

The RUC compared new code 57022 to the reference service code *56405 Incision and drainage of vulva or perineal abscess* (work RVU = 1.43). When evaluating the pre and intra-service times and intensity and complexity measures for new code 57022, these measures were greater than the reference service code 56405 due to the technical difficulty of the procedure and the need to stabilize the patient and arrange for operating room time, as this procedure is often performed on an emergent basis. Based upon the greater intensity and complexity measures for new code 57022, the RUC agreed that this procedure was more comparable to the reference service code 59160 Curettage, postpartum, which has a work RVU of 2.71. The RUC agreed that the recommended work value of 2.56, which was also the survey median work relative value was appropriate.

The RUC recommends a work relative value of 2.56 for code 57022.

The RUC noted that this recommendation is appropriate for obstetrical patients; however, incision and drainage of vaginal hematomas for sexual abuse cases represents more physician work. The RUC recommends that the specialty society pursue a new code to report this service. A new code was subsequently added by the CPT Editorial Panel. The RUC did not have an opportunity to review this service. A recommendation will be reviewed by the RUC in February 2001, and the RUC will forward the recommendation to HCFA at this time.

Practice Expense Recommendation
The direct inputs for this code were developed by a specialty consensus panel. The specialty's standard supply packages were approved by the RUC with the deletion of the autoclave from the overhead equipment category. This service is performed in a facility setting.

Hormone Pellet Implantation (TAB 10)
Presenters: George Hill, MD and Sandra Reed, MD

For CPT 2000, a new CPT code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* was added to

describe the subcutaneous placement of hormone pellets. Hormone pellets are typically inserted every three-six months and do not have to be removed. Currently, CPT does not contain an existing code that accurately describes this service; therefore the unlisted code 17999 *Unlisted procedure, skin, mucous membrane and subcutaneous tissue* is reported.

When the RUC compared new code 11980 to the reference service code 11975 *Insertion, implantable contraceptive capsules* (work RVU = 1.48), the RUC noted that the work for new code 11980 was identical to the work described by the reference service code 11975 (work RVU = 1.48). As an interim value, HCFA previously assigned a work relative value of 1.48, which is identical to the reference service code (11975). The RUC agreed the work was comparable to the reference service code and agreed the recommended survey work value of 1.48 was appropriate.

The RUC recommends a work relative value of 1.48 for code 11980.

Practice Expense Recommendations
The direct inputs were developed by a specialty consensus panel. This service may be performed in either a facility or non-facility setting. The RUC approved the use of the specialty's supply packages with the following changes:

- Deletion of the autoclave and fiberoptic exam light from the overhead equipment category for in-office services
- The Pre-clinical staff time of 2 minutes for in-office services was deleted
- The only direct input for out-of-office setting is 5 minutes of RN/LPN/MA time

Fetal Biophysical Profile (TAB 11)
Presenters: George Hill, MD, Sandra Reed, MD, James Borgstede, MD

Existing CPT code 76818 *Fetal biophysical profile* was revised to specify a fetal biophysical profile performed with non-stress testing. When performing this procedure, the physician evaluates fetal breathing movements, fetal movement, fetal tone and quantification of amniotic fluid.

The RUC compared code 76818 to the work RVU of reference service code *59025 Fetal non-stress test* (work RVU = 0.53); however this value did not include the work of the ultrasound. The RUC added the work of a limited ultrasound, code *76815 Echography, pregnant uterus, B-scan and/or real time with image documentation; limited (fetal size, heart beat, placental location, fetal position, or emergency in the delivery room)* (work RVU = 0.65) to the work RVU of code 59025 (0.53), to obtain a total relative work value of 1.18. The RUC compared this work value to the recommended work value and survey median work value of 1.05 for CPT code 76818, which the RUC agreed was an appropriate value.

The RUC recommends a work relative value of 1.05 for code 76818.

Practice Expense Recommendations
The direct inputs were developed by a specialty consensus panel. The RUC approved the supplies with minor changes and with the deletion of the tachodynanometer, autoclave, and fiberoptic exam light from the equipment categories. The RUC recommends no direct practice expense inputs in the facility setting.

76819
Work Relative Value Recommendations
New CPT code 76819 *Fetal biophysical profile; without stress or non-stress testing* was created to specify fetal biophysical profile performed without non-stress testing. When performing this procedure, the physician evaluates fetal breathing movements, fetal movement, fetal tone and quantification of amniotic fluid without performing a non-stress.

The RUC compared new code 76819 to the reference survey code 76815 (work RVU = 0.65). When evaluating the new code 76819, the time and intensity and complexity measures were greater for the new code than the reference service code (76815). Also, the physician work is more intense due to the high-risk status of the patient.

Existing code 76818 has a work RVU of 0.77 and is valued without stress or non-stress testing. Therefore, the RUC agreed that the recommended survey work RVU of 0.77 was appropriate.

The RUC recommends a work relative value of 0.77 for code 76819.

Practice Expense Recommendations
The RUC approved the recommended direct inputs with minor changes to supplies and the deletion of some overhead equipment. The laser printer was moved from the procedure specific to overhead equipment category. The RUC does not recommend any direct inputs in the facility setting.

Escharotomy (TAB 13)
Presenters: Robert W. Gillespie, MD and John W. Derr, MD

Work Relative Value Recommendation
CPT code16035 *Escharotomy; initial incision* was revised to clarify that code 16035 should be reported for a single escharotomy incision. This procedure is used in preserving pulmonary function and circulation in burn extremities. Patients requiring escharotomies generally present as emergency cases.

The RUC compared code 16035 to the reference service code 15000 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissue); first 100 sq cm or one percent of body area of infants and children* which has a work RVU of 4.00. When evaluating code 16035, the RUC noted that the urgency of medical decision-making and the risk of complications, morbidity and mortality were higher than the reference service code. As new code 16035 has greater mental effort and psychological stress, the RUC agreed that the survey

recommended work RVU of 3.75, which was also the survey median value, was appropriate. In addition, the RUC noted that the current work relative value for 16035 is 4.82. A reduction to 3.75 is appropriate, as the code will now be reported for the initial incision. If an additional incision is necessary, it will be reported with new code 16036.

The RUC recommends a work relative value of 3.75 for code 16035.

Practice Expense Recommendation

There are no direct practice expense inputs for this service, as this service is performed in a facility on an emergent basis.

16036

Work Relative Value Recommendation

CPT code 16036 *Escharotomy; each additional incision (List separately in addition to code for primary procedure)* was created to describe additional escharotomy incisions performed. Patients requiring additional escharotomy incisions are urgent cases. Currently, CPT does not contain a code that describes additional escharotomy incisions performed on a patient. CPT code 16035 *Escharotomy; initial incision* with the modifier –22 (Unusual procedural services) appended was used to describe this service. At the RUC meeting, the presenter noted that the frequency data for 16036 in the CPT Proposal was incorrect and indicated that it is estimated that 10-13% of patients require at least two incisions on a single extremity and at least four separate incisions on the chest wall.

The RUC compared new code 16036 to the reference service code 15001 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)* which has a work RVU of 1.00. The RUC noted that the complications, morbidity and mortality were greater for new code 16036 than the reference service code. There is also greater technical skill, physical and mental effort and psychological stress associated with this new procedure. Therefore, the RUC agreed that the recommended Work RVU of 1.50, which was also the survey median work value, was appropriate.

The RUC recommends a work relative value of 1.50 for code 16036.

Practice Expense Recommendation

There are no direct practice expense inputs for this service, as this service is performed in a facility on an emergent basis.

Stereotactic Breast Biopsy (TAB 14)
Presenters: James Borgstede, MD
Reviewed by Facilitation Committee 4

Work Relative Value Recommendations
New code 19102 *Biopsy of breast; percutaneous, needle core, using imaging guidance* was created to describe breast biopsy performed using imaging guidance. This procedure reflects new technology, which provides a method of breast biopsy that is minimally invasive. Per existing HCFA instructions, this service is currently being reported using CPT code 19101 *Biopsy of breast; incisional* (work RVU = 3.18).

When evaluating new code 19102 with the reference service code 19100 *Biopsy of breast; needle core (separate procedure)* (work RVU = 1.27), the RUC noted that the time and intensity and complexity measures are higher than the reference service code 19100. The RUC considered work survey results, which provided a survey median work value of 2.00. New code 19102 requires 30 minutes intra-service time compared to 10 minutes for the reference service code 19100; therefore, the RUC agreed that the recommended work relative value of 2.00 was appropriate.

The RUC recommends a work relative value of 2.00 for code 19102.

Practice Expense Recommendations
The RUC is providing recommendations for direct inputs when this service is performed in a non-facility setting only. The RUC agreed that an appropriate method for establishing clinical staff time would be to crosswalk the existing inputs from code 76942. The RUC agreed that the clinical staff activities were comparable in time (102 minutes).

Additionally, both codes 19102 and 76942 have an intra-service time of 30 minutes. The RUC further refined the clinical inputs and recommends a total clinical staff time of 100 minutes.

19103
Work Relative Value Recommendations
New code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* was created as new technology and equipment provided a new method of breast biopsy which is minimally invasive. Many of these devices are able to biopsy and remove the lesion via a minimally invasive technique.

Per existing HCFA instructions, this service is currently being reported using CPT code 19101 *Biopsy of breast; incisional* (work RVU = 3.18).

The RUC agreed that the physician work and intensity and complexity factors are greater for new code 19103 than the reference service code 19100 (work RVU = 1.27). New code 19103 has a greater complexity due to the involvement of the biopsy device, which involves complex manipulation of the device and requires additional physician time.

In addition, the RUC compared new codes 19102 and 19103 and agreed that the intensity measures in the RUC survey for 19103 reflected a more complex service than 19102. Given the additional complexity of performing the procedure, the RUC agreed that the median survey value of 2.37 was appropriate.

The RUC recommends a work relative value of 2.37 for code 19103.

Practice Expense Recommendations
The RUC is providing recommendations for direct inputs when provided in a non-facility setting only. The RUC agreed that an appropriate method for establishing clinical staff time would be to crosswalk the existing inputs from code 76942.

The RUC agreed that the clinical staff activities were comparable in time (102) minutes. Additionally, both codes 19103 and 76942 have an intra-service time of 30 minutes. The RUC further refined the clinical inputs and recommends total clinical staff time of 100 minutes.

Insertion of Breast Markers (TAB 15)
Presenters: James Borgstede, MD

CPT code 19295 *Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure)* was created to describe the placement of a metallic clip during a breast biopsy. CPT code 19295 is to be reported in addition to the code for breast biopsy.

There are no work relative value recommendations, as the RUC agreed the work for placement of the clip marker code is included in the work of the parent code.

The RUC agreed that there is minimal additional work and recommends a 0.00 work RVU for code 19295.

Practice Expense Recommendations
The RUC recommends the practice expense direct inputs for the non-facility setting. The RUC reduced the clinical staff time to two minutes to reflect an appropriate clinical staff time. Also, the RUC recommends the inclusion of marker clip as the only other practice expense input.

Mandibular Osteotomy and Genioglossus Advancement (TAB 17)
Presenter: James H. Kelly, MD, Sam McKenna, DDS, MD

New code 21199 *Osteotomy, mandible, segmental; with genioglossus advancement* was created to describe mandibular osteotomies performed with genioglossus advancement for treatment of sleep disordered breathing. Currently, CPT does not contain a code that accurately describes this procedure and this service was reported using CPT code 21198 *Osteotomy, mandible, segmental* (work RVU = 14.16) with the modifier –22 (Unusual Procedural Services).

When the RUC evaluated new code 21199, the RUC determined this new service required greater work, complexity and risk than the reference service code 21198 *Osteotomy, mandible, segmental* (work RVU = 14.16). Complex osteotomy cuts are made into the mandible to create a large window, which may weaken the bone, thereby increasing the risk for fracture during the procedure. This new service has a greater intra and post-operative risk as the patient has an obstructed airway, which can cause the patient to go from stable to worse in a matter of seconds. Typically, the patient has failed other treatments, for example continuous positive airway pressure (CPAP) and uvuloplasty before undergoing this procedure.

Also, new code 21199 is more difficult than code 21470 *Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints* (work RVU = 15.34) and code 21045 *Excision of malignant tumor of mandible; radical resection* (work RVU = 16.17). The RUC agreed that the recommended survey work value of 16.00, which was the median survey work value, was appropriate due to the greater intensity and complexity measures and increased risk to the patient.

The RUC recommends a work relative value of 16.00 for code 21199.

Practice Expense Recommendations
The direct inputs were developed by a specialty consensus panel. The specialty society used the E/M standard clinical staff time for the post-operative office visits. The specialty also explained the coordination of appropriate direct inputs. The RUC approved the practice expense inputs for 21199 with minor modifications to the supply list. This service is provided in a facility setting.

Nose Repair (TAB 18)
Presenter: James H. Kelly, MD and Lee Eisenberg, MD

New code 30465 *Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)* was created to describe surgical management of nasal obstruction due to nasal vestibular stenosis. The patient presents with collapsed valves within the nose. This procedure requires two components, revision of the nasal tip with excision of dorsal nasal skin and placement of a support so the nasal tip does not collapse. New code 30465 excludes obtaining a graft, which is obtained from a distal site and is a separately reportable service using the appropriate graft procedure code (20900-20926, 21210). Currently, CPT does not contain a code that accurately describes this service; therefore, the unlisted code 30999 *Unlisted procedure, nose* was reported.

The RUC evaluated the work survey results for code 30465, which had a recommended work survey value of 11.64, which was also the median survey work value. When the RUC compared the new code with the reference service code 30400 *Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip* (work RVU = 9.83), the new code had greater time and complexity and intensity measures, as the patients are generally sicker with comorbid conditions.

The pre- and post-service work for new code 30465 includes extensive patient support in terms of the physical disfigurement that results from the procedure. This new procedure has greater technical difficulties due to the elevation and stabilization of the nasal tip.

Additionally, resection of excessive dorsal skin is performed in conjunction with the repair of the tip ptosis. Due to the significant risk to the patient and the technical difficulty of the procedure, the RUC agreed that the recommended value of 11.64 was appropriate.

The RUC recommends a work relative value of 11.64 for code 30465.

Practice Expense Recommendations
The direct practice expense inputs were developed by a specialty consensus panel. The society used code 30400 as a reference service to determine appropriate direct inputs. The specialty also explained the coordination of care activities required.

The RUC accepted the practice expense direct inputs with minor modifications to the supplies. The specialty society used the E/M standard clinical staff time for their post-operative office visits.

Implantation or Replacement of Osseointegrated Implant Temporal Bone (TAB 19)
Presenters: James H. Kelly, MD and John Niparko, MD

69714
Work Relative Value Recommendations
New code 69714 *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy* was created to describe placement of an osseointegrated device without mastoidectomy to restore hearing sensitivity and speech. Currently, CPT does not contain a code that accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear was reported*.

The RUC compared the work survey results to survey reference code 69632 *Tympanoplasty without mastoidectomy (including canalplasty, atticottomy and/or middle ear surgery, initial or revision; with ossicular chain reconstruction (eg, postfenestration)* (work RVU = 12.75). When evaluating the results of the work survey, new code 69714 has comparable work estimates and intensity and complexity measures. The recommended work relative value for new code 69714 is slightly higher than the reference code 69632, as the intraoperative work for 69714 requires more technical skill to assure the durability of the implant. New code 69714 requires greater mental effort and judgement than the reference service code (69632). Postoperatively, new code 69714 requires more work to monitor the wound and area of the implant. Therefore, the RUC agreed that the recommended work relative value of 14.00, which is also the median survey work value, is appropriate.

The RUC recommends a work relative value recommendation of 14.00 for code 69714.

69715

Work Relative Value Recommendations

New code 69715 *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy* was created to describe placement of an osseointegrated device with mastoidectomy to restore hearing sensitivity and speech. CPT code 69715 involves greater work due to the mastoidectomy that is performed to address the chronic mastoid infections. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

The RUC compared code 69715 to the reference service code 69642 *Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction* (work RVU = 16.84) and noted that the new code 69715 requires greater time and intensity and complexity measures.

The median survey work relative value was 18.25, which the RUC agreed was an appropriate work value given the greater intensity and complexity measures for new code 697X2.

The RUC recommends a work relative value of 18.25 for code 69715.

69717

Work Relative Value Recommendations

New code 69717 *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy* was created to describe replacement of a new integrated implant without performing a mastoidectomy. New code 69717 represents a revision to code 69714, where the implant is removed and replaced. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

When evaluating new code 69717, the RUC compared this work to 69714 and agreed that the intraoperative technical skill was greater for code 69717 than in 69714. The RUC agreed the additional 0.98 RVU's added to the recommended work RVU = (14.00) for code 69714 to calculate a recommended work RVU of 14.98 for 69717 was appropriate. The RUC also compared new code 69717 to the reference service code 69711 *Removal or repair of electromagnetic bone conduction hearing device in temporal bone* (work RVU = 10.44). New code 69717 requires greater time and intensity and complexity measures than the reference service code. The RUC agreed that the recommended work relative value of 14.98, which was also the survey median value was appropriate.

The RUC recommends a work relative value of 14.98 for code 69717.

69718

Work Relative Value Recommendations

New code 69718 *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy* was created to describe replacement of a new integrated implant while performing a mastoidectomy. This code describes the replacement as well as the removal. A separate site needs to be found to place a new device; however the device is placed within in the same surgical field. Currently, CPT does not contain an existing CPT code, which accurately describes this service; therefore the unlisted code 69799 *Unlisted procedure, middle ear* was reported.

The RUC compared new code 69718 to the reference service code 69642 *Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction* (work RVU = 16.84). The RUC agreed the new code was greater in time and intensity and complexity measures than the reference service code. New code 69718 has a recommended work relative value of 18.50, which the RUC agreed was appropriate.

The RUC recommends a work relative value of 18.50 for code 69718.

Practice Expense Recommendations

The direct practice inputs were developed by a specialty consensus panel. The specialty society used the E/M standard clinical staff time for their post-operative office visits. The RUC approved the recommended inputs with only minor modifications to the supplies. All practice expense recommendations are for the facility setting only.

Speech and Auditory Evoked Potentials Services (TAB 20)

Presenters: James H. Kelly, MD and John Niparko, MD

92585

Work Relative Value Recommendation

The RUC agreed that the physician work for this service has not changed, as the revision does not relate to the physician review and interpretation.

The RUC recommends that the work of 92585 remain unchanged at 0.50 work RVU.

Practice Expense Recommendation

The RUC did approve the recommended inputs for the non-facility setting for 92585, with the deletion of several supplies. There are no direct inputs when the service is performed in a facility setting.

92586

Work Relative Value Recommendation

New code 92586 *Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited* was added to CPT to allow the reporting of state mandated testing for hearing loss in newborns to accurately bill for auditory brainstem response testing (ABRs) performed on infants that may be limited in scope.

There is currently a code 92585 for all ABRs; however, limited ABRs are being increasingly performed as part of mandated infant hearing testing by the states. The only way an audiologist can bill for these services is to append the modifier –52 (reduced services), which is unrecognized by most payers. As this new service does not typically require review by a physician, there is no physician work.

The RUC recommends no physician work relative values for code 92586.

Practice Expense Recommendation
The RUC recommends no direct practice expense inputs for 92586 as it is only performed in the facility setting.

Transmyocardial Laser Revascularization (TAB 21)
Presenter: Sidney Levitsky, MD
Reviewed by Facilitation Committee 3

New code 33141 *Transmyocardial laser revascularization, by thoractomy; performed at the time of other open cardiac procedure(s) (List separately in addition to code for primary procedure)* was created to describe transmyocardial revascularization (TMR) performed as a useful alternative or adjunct to coronary artery bypass grafting. It is especially pertinent to patients who are not candidates for coronary artery bypass grafting due to non-graftable vessels.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

There is no pre and post-service work associated with this service. There is only intra-service work associated with CPT code 33141, as code 33141 is an add-on code and is always reported in addition to another code. It was recognized that the only way to make the determination that the vessel was unsuitable for replacement would be after dissection and evaluation, and that such work would not be covered under the vessel graft service. Also, it was recognized that preparing the TMR equipment for surgical use was not included in the graft service.

In determining the intra-service work value, the RUC reviewed three activities:
1) For the first step, the RUC reviewed the differential RVU's from the CABG (vein) codes for 33510 *Coronary artery bypass, vein only; single coronary venous graft* (work RVU = 25.00), 33512 *Coronary artery bypass, vein only; three coronary venous grafts* (work RVU = 27.40), 33513 *Coronary artery bypass, vein only; four coronary venous grafts* (work RVU = 29.67), and 33514 *Coronary artery bypass, vein only; five coronary venous grafts* (work RVU = 31.95). The average differential between respective codes is 2.28 (i.e, the incremental work of dissection and replacement of a single vessel). This recognizes the incremental value of dissecting down to the vessel. The RUC agreed that for dissecting down to a vessel and then evaluating that the vessel could not be replaced, half of 2.28 (1.14) was an appropriate value.

2) For the second step, the RUC was advised that it takes approximately 20 minutes to prepare the TMR equipment for surgical use, a time component that was not considered by the surveyors. The value of this 20 minutes waiting for the equipment with a patient with an open chest and on bypass, was deemed to be similar to a little less than a half hour of critical care (1.80), and attributed 1.4 work RVU's for this element of work.

3) The Committee deemed that the 30 minutes of actual intra service time was equal to a half- hour of critical care (1.8 work RVU's) plus 0.5 work RVU's for using the laser for a total of 2.3 work RVU's.

The RUC then added these three increments of 1.14 (dissecting down to the vessel) + 1.40 (20 minutes prepare the TMR equipment) + 2.30 (actual procedure time of 30 minutes using the laser) = 4.84.

The RUC recommends a work relative value of 4.84 for code 33141.

Practice Expense Recommendations
This add-on code is only performed in a facility setting.

The RUC recommends no direct practice expense inputs.

Repair of Intracranial Aneurysm (TAB 22)
Presenters: Robert E. Florin, MD

61700
Work Relative Value Recommendation
The RUC recommends that existing code 61700 *Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation* (work RVU = 50.50) be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

61697
Work Relative Value Recommendation
The RUC recommends that new code 61697 *Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation* be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

Practice Expense Recommendation
The RUC recommends a crosswalk of the PE inputs for 61697 from 61700.

61702
Work Relative Value Recommendation
The RUC recommends that existing code 61702 *Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation* (work RVU = 48.41) be

an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

61698

Work Relative Value Recommendation

The RUC recommends that new code 61698 *Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation* be an interim RUC recommendation until such time that the neurosurgeons have time to gather further specific data regarding the difference between a complex intracranial aneurysm versus a simple intracranial aneurysm.

Practice Expense Recommendations

The RUC recommends a crosswalk of the PE inputs for 61698 from 61702.

Reprogramming of Programmable CSF Shunt (TAB 23)
Presenter: Richard Boop, MD and Greg Przybylski, MD
Reviewed by Facilitation Committee 1

New code 62252 *Reprogramming of programmable CSF shunt* was created to describe non-invasive changes in the pressure settings of programmable cerebrospinal fluid (CSF) shunts. The shunt is typically programmed through the skin using an electromagnetic current. Currently, CPT does not contain an existing CPT code that accurately identifies this service; therefore the unlisted code 95999, *Unlisted neurological or neuromuscular diagnostic procedure* was reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee 1 reviewed this issue and presented the following information.

The physician work involved in new code 62252 involves the reading of the setting of a CSF shunt valve implanted beneath the scalp. To ensure exact adjustment of the shunt valve, the physician performs specific patient positioning and x-rays before and after adjustment of the shunt valve in which the radiological services are not separately reportable.

The intra-service work for new code 62252 involves the reprogramming of the CSF shunt valve by using a hand-held electronic transmitter, as well as positioning and x-raying the patient in order to ensure the valve has been set correctly. The associated risk is high, as sudden death may occur and the setting of the valve correctly is very important to assure there is the desired pressure. The RUC adjusted the intra-service time from 15 minutes to 20 minutes to reflect the work involved for the patient positioning and x-ray time before and after shunt programming and to ensure correct valve setting.

The RUC adjusted the pre-service time from 10 minutes to 15 minutes, with the understanding that the reference code *93735 Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during*

activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming (work RVU = 0.74) has similar physician work involved. The RUC agreed the post-service time was appropriate at 10 minutes for dictation, documentation, phone calls, and discussion with the family.

The RUC came to a consensus that new code 62252 most closely resembles reference service code 93735 *Electronic analysis of single chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); with reprogramming* (work RVU = 0.74) instead of 93738 *Electronic analysis of single or dual chamber pacing cardioverter-defibrillator only (interrogation, evaluation of pulse generator status); with reprogramming* and because of this change, it was agreed that a work RVU of 0.74, rather than the specialty society recommended value of 0.92, was appropriate.

The RUC recommends a work relative value of 0.74 for code 62252.

Practice Expense Recommendation
The RUC recommends direct inputs for services performed in the non-facility setting. The RUC increased the pre-service clinical staff time from 28 to 35 minutes and approved the standard list of supplies and equipment.

Percutaneous Vertebroplasty (TAB 25)
Presenters: J. Arliss Pollock, MD; James P. Borgstede, MD; Greg Przybylski, MD; and Robert L. Vogelzand, MD
Reviewed by Facilitation Committee 2

22520
Work Relative Value Recommendations
New code 22520 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic* was created to describe minimally invasive vertebroplasty in the thoracic vertebrae. Vertebroplasty is the percutaneous skeletal fixation of a collapsed vertebral body, with access into the vertebral body achieved using radiologic imaging to access the specific vertebra and to monitor the injection of polymethylmethacrylate. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC discussed the pre-service time of 60 minutes for new code 22520 and agreed the time was appropriate. The RUC also agreed that the intra-service time of 80 minutes for code 22520 was appropriate.

The RUC discussed the post-service time on the day of the procedure and agreed that the discharge management was appropriate. However, the 99231 Hospital visit time and work should be deducted from the total time and work, as the patient is usually discharged on the same date. The RUC agreed that the service should include one 99213 office visit, not the two visits as indicated in the survey. The RUC deducted the hospital visit and one office visit to arrive at a work value of 8.91 for code 22520.

The RUC recommends a work relative value of 8.91 for code 22520.

Practice Expense Recommendations

This service is only provided in a facility setting; therefore, the RUC recommends that the E/M package for clinical staff time, supplies and equipment for the 99213 level of office visit be included in the post-operative period for code 22520. The E/M standard package for 99213 is listed below:

Clinical Labor	RN/LPN/MA	36 minutes
Medical Supplies:		
Drape Sheet		1 item
Exam table paper		7 feet
Pillow case		1 item
Gloves, non-sterile		2 pair
Otoscope speculum disposable		1 item
Patient education booklet		1 item
Patient gown, disposable		1 item
Swab, alcohol		2 items
Thermometer probe cover, disposable		1 item
Tongue depressor		1 item
Overhead Equipment:		
Exam table		
Crash cart, no defibrillator		
Otoscope-ophthalmoscope		

This service is only provided in a facility setting, therefore, the RUC agreed that 1 post operative visit was appropriate within the global period.

22521

Work Relative Value Recommendations

New code 22521 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar* was created to describe minimally invasive vertebroplasty in the lumbar vertebrae. Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC discussed the pre-service time of 60 minutes for new code 22521 and agreed the time was appropriate. The RUC also agreed that the intra-service time of 80 minutes for code 22521 was appropriate. The RUC discussed the post-service time on the day of the procedure and agreed that the discharge management was appropriate.

However, the 99231 Hospital visit time and work should be deducted from the total time and work, as the patient is usually discharged on the same date. The RUC agreed that the service should include one 99213 office visit, not the two visits as indicated in the survey.

The RUC deducted the hospital visit and one office visit to arrive at a work value of 8.34 for code 22521.

The RUC recommends a work relative value of 8.34 for code 22521.

Practice Expense Recommendations
This service is performed only in a facility setting; therefore, the RUC recommends that the E/M package for clinical staff time, supplies and equipment for the 99213 level of office visit be included in the post-operative period for code 22521. The E/M standard package for 99213 is listed below:

Clinical Labor	RN/LPN/MA	36 minutes
Medical Supplies:		
Drape Sheet		1 item
Exam table paper		7 feet
Pillow case		1 item
Gloves, non-sterile		2 pair
Otoscope speculum disposable		1 item
Patient education booklet		1 item
Patient gown, disposable		1 item
Swab, alcohol		2 items
Thermometer probe cover, disposable		1 item
Tongue depressor		1 item
Overhead Equipment:		
Exam table		
Crash cart, no defibrillator		
Otoscope-ophthalmoscope		

This service is only provided in a facility setting, therefore, the RUC agreed that one post operative visit was appropriate within the global period.

22522
Work Relative Value Recommendations
New code 22522 *Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)* was created to describe minimally invasive vertebroplasty in additional lumbar or thoracic vertebrae.

Currently, CPT does not contain an existing code that accurately describes this service; therefore, the unlisted code 22899 *Unlisted procedure, spine* is reported.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Two reviewed this issue and presented the following information.

The RUC agreed that code 22522 should represent an average of half (50%) of the recommended work RVU of 22520 (4.45), and 22521 (4.17), which is a total of 4.31 work RVU's.

The RUC recommends a work relative value of 4.31 for code 22522.

Practice Expense Recommendations
There are no direct practice expense inputs, as code 22522 is on add-on code performed only in a facility setting.

76012
Work Relative Value Recommendations
New code 76012 *Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under fluoroscopic guidance* describes the radiologic portion of using fluoroscopy to access the specific vertebra, place the needle and monitor the injection of polymethylmethacrylate.

The survey median for code 76012 was 1.31. The RUC agreed that this value was appropriate for the work involved. The RUC compared new code 76012 to the reference service code 75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation,* which has the same intra-service time. The RUC agreed that the physician pre-service time for 76012 should be deleted, as it overlaps with the percutaneous vertebroplasty codes. The RUC recommends that the survey work relative value median be approved for 1.31.

The RUC recommends a work relative value of 1.31 for code 76012.

Practice Expense Recommendations
There are no direct practice expense inputs as this service is only performed in a facility setting.

76013
Work Relative Value Recommendations
New code 76013 *Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under CT guidance* describes the radiologic portion of using CT guidance to access the specific vertebra, place the needle and monitor the injection of polymethylmethacrylate.

The RUC compared code 76013 and agreed the intensity and number of films to be taken are greater in code 76013 than 76012. The RUC agreed that the relativity of the

original specialty recommendations presented for codes 76012 (1.16) and 76013 (1.22) be maintained and therefore; the RUC agreed that a work relative value of 1.38 was appropriate.

The RUC recommends a work relative value of 1.38 for code 76013.

Practice Expense Recommendations
There are no direct practice expense inputs, as this service is performed only in a facility.

Endovascular Graft for Abdominal Aortic Aneurysm (TAB 26)
Presenters: Gary Seabrook, MD; Robert Vogelzang, MD; and James P. Borgstede, MD
Reviewed by Facilitation Committee 3

New CPT codes were created to describe procedures related to endovascular abdominal aortic aneurysm repair. New codes 34800-34826 describe the placement of the endovascular graft for abdominal aortic aneurysm repair under fluoroscopic guidance. New codes 34830-34832 describe open repair of an infrarenal aortic aneurysm following unsuccessful endovascular repair. Two new codes 75952 and 75953 were created to describe fluoroscopic guidance in conjunction with endovascular aneurysm repair.

The RUC did not accept the initial specialty society work value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

The Committee considered whether or not the Societies' description of the coding for services adjunctive to the respective presented services was consistent with current accepted coding practices. The Committee was advised that the society's description was correct. However, it was suggested that the CPT introductory notes to "Endovascular Repair of Abdominal Aortic Aneurysm" be revised to better clarify the appropriate coding of relevant multiple services provided in a single session.

The RUC considered the format of the survey instruments utilized in the presentation. It was clarified that in each case, the surveys included CPT code, global period designation, CPT descriptor, vignette, and descriptions of pre-service work, intra-service work inclusions, post-work, and services that could be separately billable and therefore not included in the surveyed service. The clinical description of pre-intra-post-service work was not provided to the surveyees. There was discussion of possible effects of the statement of the excluded services. It was the consensus of the committee that given the intricacies of the accepted coding for these types of services, stimulating the list of excluded services better ensured that the work of the respective presented service was appropriately surveyed.

34800
New code 34800 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis* was created to describe deployment of an

aorto-aortic tube prosthesis. The RUC reviewed codes 35102 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)* (work RVU = 30.76; global 090) and reference service code 35081 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm and associated occlusive disease, abdominal aorta* (work RVU = 28.01; global 090) and determined a difference of 2.75 work RVU's for involvement of iliac vessels. This was compared to the differential of 2.25 between 34800 and 34802. The RUC agreed that this differential was appropriate.

The RUC recommends a work value of 20.75 for code 34800.

34802

New code 34802 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)* describes the deployment of a modular bifurcated endovascular prosthesis. When performing this service, there is a need to access the femoral artery (34812), which is the open femoral artery exposure. Imaging 75952 constitutes the imaging of all the services (e.g., ballooning, stenting) and is only reported one time.

The recommended work value for code 34802 is 23.00. The pre-service time (135 minutes) is relatively higher than the reference service code 35102 (95 minutes), as review of CT scans and aortograms is performed, measurement of the diameter and length of the graft is needed and ordering of the graft is performed, which is included in the new code and is not captured with a separate E/M code or other service code.

The RUC agreed that CPT code 35102 *Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft;* (work RVU = 30.76; global 090) was a reasonable reference code for this service. The RUC discussed the service times for reference service code 35102 (180 minutes) and noted they are higher than compared to the new code 34802 (150 minutes). The RUC recognized that the societies recommended the 25th percentile work RVU = 23.00 based upon two validation methodologies.

The RUC agreed that the recommended work value of 23.00 was appropriate.

The RUC recommends a work relative value of 23.00 for code 34802.

34804

New code 34804 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis* was created to describe deployment of a unibody bifurcated endovascular prosthesis.

The specialty society presented the survey 25th percentile work RVU of 23.00. The RUC was comfortable that this service was similar in work to 34802. The RUC agreed that this was an appropriate work relative value for this service.

The RUC recommends a work relative value of 23.00 for code 34804.

34808

New code 34808 Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure) *was created to describe endovascular placement of an iliac artery occlusion device.*

The RUC determined that this code would not be independently performed. **Therefore, the RUC recommends that it be designated a ZZZ global.** The RUC reviewed code 37206 Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure) (work RVU = 4.13; global ZZZ) and agreed that it was comparable to 34808.

The RUC recommends a work value of 4.13 for code 34808.

34812

New code 34812 *Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral* was created to describe open surgical exposure of the femoral artery via a unilateral groin incision to expose a site on the artery through which catheters, guidewires, and endovascular prosthetic components are delivered.

After much discussion, the RUC deemed that this service was very similar in work to 33970 *Insertion of intra-aortic balloon assist device through the femoral artery, open approach* (work RVU = 6.75; global 000) and that the 090 global designation was inappropriate for 34812.

With reduction to a 000 global, the RUC recommends the work relative value of 6.75 for code 34812.

34813

New code 34813 *Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)* was created to describe the open bilateral femoral artery exposure for the deployment of the endovascular prosthesis. The RUC reviewed code 35661 *Bypass graft, with other than vein; femoral-femoral* (work RVU = 13.81; global 090) and reduced this value by 6.75 work RVU for one groin and half of 6.75 (3.38) for the second groin to arrive at a work value of 3.68. In addition, the combination of two artery exposures plus one femoral-femoral graft has very close work equivalent to the reference service code 35656 *Bypass graft, with other than vein; femoral-popliteal.* Given these calculations, the RUC agreed comfortable with the originally recommended value of 4.80.

The question was raised regarding what would be done if 34812 and 34813 were performed without introduction of a device. The RUC agreed that there should be a CPT note that indicates that if these are performed without the delivery of an endovascular prosthesis, there should be an appropriate cross reference in CPT (perhaps directing to 35661). The presenters agreed that it would be appropriate to ask for such an editorial change.

The RUC recommends a work relative value of 4.80 for code 34813. The RUC recommends that CPT review appropriate guidelines when 34812 and 34813 are performed without introduction of an endovascular prosthesis.

34820

New code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision; unilateral* was created to describe the open surgical exposure of the iliac arteries via a retroperitoneal or abdominal approach. This procedure may be performed when the femoral arteries are diseased or inadequate diameter to allow passage of the large endovascular introducer sheaths.

The RUC compared code 49010 *Exploration, retroperitoneal area with or without biopsy(s) (separate procedure*) (work RVU = 12.28; global 090) and agreed that this service was roughly comparable to the work of 34820. However, the RUC agreed that 34820 would be better designated as a 000 global and decided to delete the after service care resulting in a work RVU of 9.75.

The RUC recommends a work relative value of 9.75 for code 34820. The Committee also recommends a 000 global.

34825

New code 34825 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel* was created to describe placement of a proximal or distal extension prosthesis in an initial vessel for endovascular repair of an infrarenal abdominal aortic aneurysm. The RUC agreed with the survey median, of which 54 vascular surgeons indicated the appropriate work relative value should be 12.00.

The RUC recommends a work relative value of 12.00 for code 34825.

34826

New code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; each additional vessel (List separately in addition to code for primary procedure)* was created to describe placement of a proximal or distal extension prosthesis in each additional vessel, for endovascular repair of an infrarenal abdominal aortic aneurysm. The RUC compared new code 34826 to the reference service code 37208 *Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure)* and noted that the intra-service time is identical.

However, new code 34826 has greater time, and intensity and complexity measures than the reference service code.

The RUC identified that this would only be performed with 34825 and agreed the recommended work value of 4.13 was appropriate for code 34826.

34830

New code 34830 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed.

The RUC compared 35081(work RVU = 28.01) and 35082 *Direct repair or aneurysm, false aneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU = 36.35) and agreed that the work of 34830 was roughly in the mid-range of these two services.

The RUC recommends a work relative value of 32.59 for code 34830.

34831

New code 34831 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed.

The RUC compared reference service codes 35081 (work RVU = 28.01) and 35102 (work RVU = 30.76) and calculated a difference of 2.75 work RVU's between these two codes. When this was added to 34830, the resulting work RVU was 35.34.

The RUC recommends a work relative value of 35.34 for code 34831.

34832

New code 3483*2 Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis* describes open repair of an abdominal aortic aneurysm following unsuccessful endovascular approach. This code is used in the instance when an endovascular approach was unsuccessful and a conversion to open repair is performed. The RUC determined that the work of 34832 was equivalent to 34831.

Therefore, the RUC recommends a work relative value of 35.34 for code 34832.

75952

New code 75952 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation* was created to describe the radiological supervision and interpretation which includes angiography of the aorta and

its branches for diagnostic imaging prior to deployment of the endovascular device(s), fluoroscopy for guidance in the delivery of the endovascular components and subsequent arterial imaging to confirm appropriate position of the graft, detect endoleaks, and evaluate the status of the runoff vessels.

The RUC was concerned that the low number of survey responses from Interventional Radiologists might have inappropriately skewed the survey results. Therefore, the RUC agreed that any value approved should be an interim value until the Interventional Radiologists conduct another survey.

Based upon this concern, the RUC decided to take the mid-point value between the median of 3.50 work RVU and the Society's recommended work value of 4.50.

The RUC recommends an interim work relative value of 4.00 for code 75952.

75953

New code 75953 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm, radiological supervision and interpretation* describes the radiological supervision and interpretation for the placement of the proximal or distal extension prosthesis.

The RUC noted that the Society's presented a recommendation of 1.36 work RVU, which was less than their 25th percentile.

The Committee recommends a work value of 1.36 for code 75953.

Practice Expense Recommendations

The RUC approved a Facilitation Committee report that reviewed the direct inputs for the new endovascular graft codes. The RUC agreed to a standard pre-service time of 45 minutes for the 090 day global codes 34800, 34802, 34804, 34825 and 34830, 34831, and 34832. The RUC then assigned the standard E/M clinical staff times for the number and levels of office visits for each of these codes. In addition, these codes also were assigned the standard basic post operative incision care kit for the first office visit and then the standard minimum E/M supply packaged for each office visit. Since these procedures are performed in the facility setting, the RUC did not assign any procedure specific equipment. However, the standard E/M overhead equipment was included.

Percutaneous Management of Dialysis Graft/Fistula (TAB 27)
Presenters: James Borgstede, MD, and Robert Vogelzang, MD
Reviewed by Facilitation Committee 3

New code 36870 *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* was created to describe percutaneous treatment of a thrombosed hemodialysis graft or fistula. Currently, CPT does not contain a code that accurately describes this service; therefore the unlisted code 37799 *Unlisted procedure, vascular surgery* was reported.

The RUC did not accept the initial specialty society work relative value recommendation. Facilitation Committee Three reviewed this issue and presented the following information.

The RUC evaluated new code 36870 *Thrombectomy, percutaneous arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)* which had a recommended work RVU of 6.85. This recommended value is also the survey median work value.

The RUC identified that there are three services that will always be provided together; new code 36870 (Societies' recommended work RVU of 6.85; 090 global), 36145 *Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)* (work RVU = 2.01), and 75790 Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation (work RVU = 1.84).

36870	*6.85*
*36145 (2.01 * .5)*	
(50% reduction)	*1.00*
75790	*1.84*
	9.69

The RUC agreed that the complete service should be directly comparable to the open code. The RUC evaluated code 36831 *Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft* (work RVU = 8.00; 090 global). The RUC; therefore, reduced the open code's total work RVU of 8.00 by 1.00 (50% of 36145) and 1.84 (75790), with the resulting work RVU = 5.16.

The RUC also reviewed code 36860 *External cannula declotting; without balloon catheter* (work RVU = 2.01; 000 global) and 35473 *Transluminal balloon angioplasty, percutaneous; iliac* (work RVU = 6.04; 000 global) and determined that this 36870 was roughly in this range. The Societies' agreed to a value of 5.16, recognizing that it also incorporated a 090 global.

The RUC recommends a work relative value of 5.16 for code 36870.

Practice Expense Recommendations

The RUC approved a Facilitation Committee report that reviewed the direct inputs for Percutaneous Management of Dialysis Graft/Fistula when performed in a non-facility setting. The RUC agreed with the facilitation committee that a pre-service time of 15 minutes, a service period time of 115 minutes, and post service time of 5 minutes, was appropriate for this procedure. One physician 99212 office visit is included in the global period, with the specialty noting that this visit would require less time than the standard 99212 and recommends 16 minutes of clinical staff time. Revised medical supplies and equipment were also submitted by the facilitation committee and approved by the RUC.

Naso-or-Oro-gastric Tube Placement
Presenters: James P. Borgstede, MD and Joel Brill, MD

Work Relative Value Recommendation
New code 43752 *Naso- or oro-gastric tube placement, necessitating physician skill* was created to describe the instance wherein naso-gastric tube placement required additional skill or involved additional risk in which a physician's skill is required. Generally, these services are performed by non-physician clinical staff; however, if multiple attempts taken by non-physician personnel to place the tube were unsuccessful, this would then require a physician's skill to place the tube in which CPT currently does not contain a code.

The RUC has not developed a specific work relative value recommendation for new CPT code 43752 *Naso- or oro-gastric tube placement, necessitating physician skill* and had requested that the CPT Editorial Panel reconsider the nomenclature for this service.

The Editorial Panel did add the note under CPT 44500 *Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)* to specify that NG tube placement be reported utilizing the new code 43752; however, the CPT Editorial Panel did not revise the nomenclature for 43752.

The RUC will reconsider this issue at the February 2001 meeting and will forward any recommendations to HCFA at that time.

GI Endoscopy Procedures (TAB 29)
Presenters: Joel Brill, MD
Reviewed by Pre-Facilitation Committee 3

The specialty societies presenting relative value recommendations for Gastrointestinal Endoscopy Procedures at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

In developing interim recommendations for these new endoscopy procedures, the RUC reviewed the current relationships within existing codes and determined an appropriate increment for both the transendoscopic ultrasound and the needle/aspiration/biopsy. The RUC recommends the following interim work RVUs:

43200	*Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	*1.59*
43202	*with biopsy, single or multiple*	*1.89*
43231 (Y1)	**Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination**	**4.09**

43232 (Y2)	**with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**	**4.71**
43235	*Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	*2.39*
43259	*with endoscopic ultrasound examination*	*4.89*
43242 (Y3)	**with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**	**5.51**
43240 (Y4)	**with transmural drainage of pseudocyst**	**7.39**
45330	*Sigmoidoscopy, flexible; diagnostic, with or without collection of of specimen(s) by brushing or washing (separate procedure)*	*.96*
45341 (Y5)	**with endoscopic ultrasound examination**	**3.46**
45342 (Y6)	with transendoscopic ultrasound-guided intramural or **transmural fine needle aspiration/biopsy(s)**	4.08

The rationale for each is as follows:

Y1 = 43200 (1.59) + 2.50 (ultrasound increment)* = 4.09

Y2 = Y1 (4.09) + .62 (biopsy increment)** = 4.71

Y3 = 43259 (4.89) + .62 (biopsy increment)** = 5.51

Y4 = The RUC recommends that this service is equivalent to code 43262 *Endoscopic retrograde cholangio-pancreatography (ERCP); with sphincterotomy/papilotomy* (work RVU = 7.39*). The specialty's survey data indicated that the total time for this new CPT code is 130 minutes, which is directly comparable to the Harvard total time of 137 minutes for 43262.*

Y5 = 45330 (.96) + 2.50 (ultrasound increment)* = 3.46

Y6= Y5 + .62 (biopsy increment)** = 4.08

*Ultrasound increment = 43259 (4.89) – 43235 (2.39) = 2.50

**Biopsy increment = Blend between 19291 *Preoperative placement of needle localization wire, breast; each additional lesion* (0.63) and the increment between 31629 *Bronchoscopy, (rigid or flexible); with transbronchial needle aspiration biopsy* (work RVU = 3.37) and 31622 *Bronchoscopy (rigid or flexible); diagnostic with or without cell washing (separate procedure)* (work RVU = 2.78) of .59.

Practice Expense Recommendation
The following applies to codes 43231, 43232, 43242, 43240, 45341, 45342 (Y1-Y6). Practice Expense inputs agreed upon at the pre-facilitation meeting were as follows

35 minutes pre-service time RN/MA/LPN
10 minutes coordination of care RN/MA/LPN
10 minutes post-telephone calls RN/MA/LPN

No Medical Supplies
No Equipment
These services are performed in a facility setting.

Endoscopic Enteral Stenting (TAB 30)
Presenters: Joel Brill, MD
Reviewed by Pre-Facilitation Committee 3

The specialty societies presenting relative value recommendations for Endoscopic Enteral Stenting at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

In developing interim RUC recommendations for these codes, the committee established an increment that could be applied to each base code for the "transendoscopic stent placement (includes predilation)" component. The RUC determined this increment by adding a component for placement of stent with a component to represent the work inherent in utilizing a guidewire, as follows:

43219	*Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent*	2.80
43200	*Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	1.59
	Increment for Placement of Stent	**1.21**
43226	*Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire*	2.34
43200	*Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*	1.59
	Increment for Guidewire	***0.75***
	Increment for "transendoscopic stent placement (includes predilation)"	***1.96***

Based on this increment, the RUC recommends the following interim work relative value recommendations:

44397

New code 44397 *Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)* was created to describe stent placement via colonoscopy through a stoma, for duodenal and colonic obstructions or with gastric outlet strictures caused by malignant neoplasms. Stent placement also provides a solution for relieving large bowel obstruction prior to colectomy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Colonoscopy through stoma; with transendoscopic stent placement (includes predilation) = 44388 *Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 2.82 + 1.96 = **4.78**.

45327

New code 45327 *Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation*) was created to describe stent placement during a rigid proctosigmoidoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation) = 45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 0.70 + 1.96 = **2.66**.

45345

New code 45345 *Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)* was created to describe stent placement during a flexible sigmoidoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation) = 45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* 0.96 + 1.96 = **2.92**.

45387

New code 45387 *Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)* was created stent placement during a flexible colonoscopy. Currently, CPT does not contain an existing CPT code that accurately describes placement of an enteral stent; therefore, the unlisted code 45999 *Unlisted procedure, rectum* was reported.

Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation) = 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon depression (separate procedure)* 3.70 +1.96 = **5.66**.

Other New Codes:
The CPT Editorial Panel approved new codes (43256, 44370, 44379 and 44383) at the May 2000 meeting. The RUC; therefore, did not have the opportunity to review these services. The RUC will forward recommendations after February 2001.

Practice Expense Recommendation
The following applies to codes 44397, 45327, 45345, and 45387.
Practice Expense inputs agreed upon at the pre-facilitation meeting were as follows:

35 minutes pre-service time RN/MA/LPN
10 minutes coordination of care RN/MA/LPN
10 minutes post-telephone calls RN/MA/LPN
No Medical Supplies
No Equipment
These services are performed in the facility setting.

Cutaneous Electrogastrography Provocative Testing (TAB 31)
Presenters: Joel Brill, MD

91132
New code 91132 *Electrogastrography, diagnostic, transcutaneous* was created to describe a procedure performed for diagnosing disorders of gastric motility which frequently involves the electrical activity of the stomach. An EGG device is positioned on the abdomen and usually placed over the epigastrium and an EGG is performed.

The RUC recommends that CPT code 91132 (VV1) be carrier-priced as currently very few physicians in the United States are performing these services. After these services become more widespread, the specialty societies will present relative value recommendations to the RUC.

91133
New code 91133 *Electrogastrography, diagnostic, transcutaneous; with provocative testing* was created to describe a procedure performed for diagnosing disorders of gastric motility which frequently involves the electrical activity of the stomach. New code 91133 includes provocative testing.

The RUC recommends that these services be carrier-priced as currently very few physicians in the United States are performing these services. After these services become more widespread, the specialty societies will present relative value recommendations to the RUC.

Photodynamic Therapy (TAB A)
Presenters: Joel Brill, MD
Reviewed by Pre-Facilitation Committee 3

96570

Work Relative Value Recommendations

CPT code 96570 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)* was created to describe photodynamic therapy used for treatment in esophageal cancer.

CPT code 96570 is used to report the application of a light source to activate the photoactive drug, for the first 30 minutes. A continuous wave of argon-pumped dye laser is used to deliver a red light to the target tissues containing the photoactive drug. Upon application of the light, the photoactive drug produces single oxygen destroying the cells in which the drug has collected.

The specialty societies presenting relative value recommendations for Photodynamic Therapy at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

These codes were added to CPT in 2000 and therefore, HCFA has already established relative values for these services. The RUC reviewed the current work relative values for these add-on codes and thought that they were reasonable and agreed that they be proposed as interim RUC recommendations.

96570 (XX1)	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately; in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)	**1.10**

Practice Expense Recommendations

As CPT code 96570 is an add-on code with a global period of ZZZ, there are no practice expense inputs.

96571

Work Relative Value Recommendations

New code 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)* was created to describe photodynamic therapy used for treatment in esophageal cancer. Code 96571 is used to report the application of a light source to activate the photoactive drug for each additional 15-minutes after the first initial 30 minutes.

A continuous wave of argon-pumped dye laser is used to deliver a red light to the target tissues containing the photoactive drug. Upon application of the light, the photoactive drug produces single oxygen destroying the cells in which the drug has collected.

The specialty societies presenting relative value recommendations for Photodynamic Therapy at the RUC recognized that their survey data was insufficient and requested the RUC to develop interim recommendations for these new CPT codes. This issue will be reviewed again by the specialty societies and any new recommendations will be presented at the February 2001 RUC meeting. The RUC will reconsider this issue and will forward any recommendations to HCFA at that time.

These codes were added to CPT in 2000 and therefore, HCFA has already established relative values for these services. The RUC reviewed the current work relative values for these add-on codes and thought that they were reasonable and agreed that they be proposed as interim RUC recommendations.

96571 (XX2) each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus) **0.55**

Practice Expense Recommendation
As CPT code 96571 is an add-on code with a global period of ZZZ, there are no practice expense inputs.

Medical Nutrition Therapy (TAB B)
This issue has been referred back to the CPT Editorial Panel for further review.

Collection of blood specimen from venous access device (TAB C)
Presenters: John Pippen, MD

Work Relative Value Recommendations
New code 36540 *Collection of blood specimen from a partially or completely implantable venous access device* was created to describe the collection of blood specimens from an implantable venous access port. Venous access ports are implanted in patients who require recurrent venous access for therapeutic intervention; however, these access ports may also be used to draw blood for laboratory testing. Currently, CPT does not contain an existing code that describes venous access for collection of a blood specimen from an implantable access port.

The RUC agreed with the specialty society that there is no physician work involved in the new code 36540 *Collection of blood specimen from a partially or completely implantable venous access device.*

Practice Expense Recommendations
The RUC recommends that the practice expense inputs for new code 36540 be forwarded to HCFA with no clinical time. The RUC agreed that for this new code to be performed in a non-facility setting, the attached medical supplies and equipment were necessary.

Computed Tomography Angiography (TAB D)
Presenters: James P. Borgstede, MD and J. Arliss Pollock, MD

Work Relative Value Recommendations
Although the CPT Editorial Panel approved eight new codes for computed tomographic angiography, the radiologists presented recommendations for only two codes in this family. The RUC, therefore, is presenting recommendations for the following two codes in this series of eight codes.

70496
New code 70496 *Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s), including image post-processing* was created to describe CTA of the head without contrast materials followed by contrast material. This is a new technique used for imaging vessels. The information gathered from CTAs is used in the evaluation of vascular anatomy, vascular disorders such as aneurysms, stenoses, cases of suspected vascular trauma, and in the follow-up of organ transplantation.

70496 (SS1) Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s), including image post-processing **1.75**

70498
New code 70498 *Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s), including image post-processing* was created to describe CTA of the neck without contrast materials followed by contrast material. This is a new technique used for imaging vessels.

70498 (SS2) Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s), including image post-processing **1.75**

The specialty society may present recommendations on the remaining six codes from this family at the February 2001 RUC meeting. The RUC will forward any resulting recommendations to HCFA after this meeting.

The RUC agreed that these services were most similar in work to CPT code 70541 *Magnetic resonance angiography, head and/or neck, with or without contrast material(s)* (work RVU = 1.81). The specialty's survey data indicated that these new services require 37-38 minutes of physician time. This is comparable to the previous RUC survey total time for 70541 of 40 minutes. The patients who receive CTA are patients that typically are unable to utilize the MRA, as they may have a pacemaker or aneurysm clip or are claustrophobic or unwilling to remain motionless.

The RUC also reviewed the relationship of these new services to the existing CT codes, including 70470 *Computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27) and

70492 *Computerized axial tomography, soft tissue neck; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.45) and agreed that these CTA services require significantly more physician time than traditional CT as there are more studies to review.

Practice Expense Recommendations
The RUC agreed that the list of direct practice expenses accurately reflected the resources required for each of the procedures, 70496 and 70498, in the non-facility setting.

Magnetic Resonance Imaging (TAB E)
Presenters: James P. Borgstede, MD and J. Arliss Pollock, MD
Reviewed by Facilitation Committee 4

Work Relative Value Recommendations
The CPT Editorial Panel has revised five Magnetic Resonance Imaging (MRI) codes and added ten codes to specify MRI without contrast; with contrast; and without contrast material, followed by contrast material(s) and further sequences.

The specialty has only presented recommendations for three codes that represent MRI for orbit, face, and neck.

The specialty society may present recommendations on the remaining twenty-one MRI codes at the February 2001 RUC meeting. The RUC will forward any resulting recommendations to HCFA after this meeting.

The RUC understands that when these MRI codes were evaluated, gadolinium (contrast material) was not in widespread use and therefore, code 70540 *Magnetic resonance (eg, proton) imaging, orbit, face, and neck* (work RVU = 1.48) was valued assuming "without contrast material." The RUC recommendations, therefore, that revised 70540 be considered editorial and reflect no change in work.

The RUC did not agree with the increment proposed by the specialty for adding "contrast materials" and "without contrast materials, followed by contrast material(s) and further sequences." The RUC recommends that an increment of .30 to reflect the additional physician work in performing the MRI with contrast materials. The RUC determined that the current increment between codes 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.48) and 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material* (work RVU = 1.78) is appropriate. This increment of .30 should be added to 70540 to determine a recommended work relative value of 1.78 for 70542 *Magnetic resonance (eg, proton) imaging, orbit, face, and neck; with contrast material.*

Code 70543 *Magnetic resonance (eg, proton) imaging, orbit, face and neck; without contrast material, followed by contrast material(s) and further sequences should be valued at* 70540 (1.48) and ½ 70542 (1.78) for a recommended work RVU of 2.36.

This is also consistent with the increment between codes 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (work RVU = 1.48) and 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU = 2.36).

Practice Expense Recommendations
The RUC agreed with the facilitation committee's recommendation that all three codes, 70540, 70542, and 70543, be cross walked to existing CPEP inputs for codes 70551, 70552, 70553.

Magnetic Resonance Angiography (Head and Neck) (TAB F)
Presenters: J. Arliss Pollock, MD and James. P. Borgstede, MD
Reviewed by Facilitation Committee 4

Work Relative Value Recommendations
The CPT Editorial Panel deleted the current code 70541 *Magnetic resonance angiography, head and/or neck, with or without contrast material(s)* (work RVU = 1.81) and replaced this code with six new codes to differentiate magnetic resonance angiography (MRA) for head and MRA for neck, and to indicate performance of studies with contrast. Distinct codes to describe the anatomical sites is justified as these two services, if done at the same patient encounter, require removal of the patient from the magnet bore, placement of separate MR imaging coils for the evaluation of distinct anatomic regions, and re-centering the patient, including new scout sequences. Two separate studies are produced and must be interpreted and reported separately.

In addition, no current codes exist for the performance of these studies with the dynamic administration of contrast materials, which was not generally utilized for this procedure when the code was originally developed in 1994. The RUC agreed with this argument and would like to emphasize to HCFA that these new codes report new technology, therefore, work neutrality should not be an issue.

The RUC reviewed the existing RUC survey time for code 70541 of 41 minutes and compared this to the surveyed time for the six new services. The RUC also reviewed the current work relative value for 70541 of 1.81 and agreed that 1.20 was reasonable for each anatomical site (head and neck) with or without contrast. Based on this review, the RUC agreed that the specialty society recommendations were appropriate as listed below:

70544	MRA, head; without contrast material	1.20
70545	with contrast material (s)	1.20
70546	with contrast, followed by contrast	1.80
70547	MRA, neck; without contrast material	1.20
70548	with contrast material (s)	1.20
70549	with contrast, followed by contrast	1.80

Codes 70546 and 70549 reflect the addition of the work relative value for 70544/70547 and ½ the work relative value for 70545/70548 (1.20+. 60 = 1.80).

Practice Expense Recommendations
The RUC recommended direct practice expense inputs for services performed in a non-facility setting. The RUC reduced the proposed time of 10 minutes to greet the patient to the standard time of three minutes. A series of modifications were also made to the supplies and equipment.

Magnetic Resonance Guidance Tab (TAB G)
Presenters: James P. Borgstede, MD and Robert Vogelzang, MD

Work Relative Value Recommendations
New code 76393 *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation* was created to describe MR guidance.

MR guidance is used to assist in the associated procedures (e.g., biopsy) for minimally invasive tissue sampling, fluid collection, as well as for guidance of injection of diagnostic substances. Currently, CPT does not contain an existing code that accurately describes MR guidance for needle placement; therefore the unlisted code 76499 *Unlisted diagnostic radiologic procedure* was reported.

The RUC recommends that the work relative value unit for 76393 *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation* be 1.50. The RUC agreed that 76393 is more work than 76360 *Computed tomography guidance for needle biopsy, radiological supervision and interpretation* (work RVU = 1.16) as this new service requires more physician time and has a higher level of intensity than 76360, as indicated in the specialty's survey data.

The RUC recommends a work relative value of 1.50 for code 76393.

Practice Expense Recommendations
The direct practice expense inputs for services performed in a non-facility setting reflect a RUC reduction of clinical staff time to 45 minutes, as well as, deletions in the medical supplies and overhead equipment categories.

Gait and Motion Analysis (TAB H)

Work Relative Value Recommendations
The RUC accepted the motion to refer the Gait and Motion Analysis codes back to the CPT Editorial Panel for reconsideration for further action.
The RUC recommended that these codes be carrier priced for 2001.

Practice Expense Recommendations
There are no direct practice expense recommendations.

Anesthesia Services (TAB I)
Presenter: Karl E. Becker, Jr., MD

Base Unit Recommendations
The RUC recommends the base units as presented by the American Society of Anesthesiology be interim values until the RUC has the opportunity to review these services and will forward to HCFA final recommendations when the RUC has the opportunity to do so.

Doctor Hoehn assigned RUC members William Gee, MD; Robert Zwolak, MD; William Rich, MD; Richard Haynes, MD, Richard Whitten, MD; and J. Leonard Lichtenfeld, MD to an Anesthesia Facilitation Committee. Doctor Hoehn specified that a conference call and meeting should be scheduled prior to the October, 2000 RUC meeting to review these recommendations for the anesthesia codes and echocardiography code and develop a report to the RUC for consideration.

Practice Expense Recommendations
The Specialty Society presented that these services are performed in the facility setting and; therefore, would not have any direct practice expense recommendations. The RUC; therefore, recommends no direct practice expense inputs for these codes.

Echocardiography (TAB J)
Presenters: Karl E. Becker, Jr., MD

Work Relative Value Recommendations
The RUC will consider this issue along with the other anesthesia services during the October 2000 RUC meeting and will forward any recommendations to HCFA at that time.

Practice Expense Recommendations
The Specialty Society presented that these services are performed in the facility setting and; therefore, would not have any direct practice expense recommendations. The RUC, therefore, recommends no direct practice expense inputs for these codes.

Intracardiac Echocardiography during Therapeutic/Diagnostic Intervention (TAB K)
Presenters: James Maloney, MD and David Schwartzman, MD

Work Relative Value Recommendations
New code 93662 *Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)* was created to describe intracardiac echocardiography which is an imaging tool used with interventional cardiology and electrophysiology applications. Using this technology, the physician is able to directly image cardiac structures and catheter position relative to cardiac anatomy during procedures.

The RUC compared new code 93662 to the reference service code 92978 *Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80). New code 93662 has a higher intra-service time than the reference code, in which the 55 minutes is dedicated to the imaging itself, which is performed during and following the primary procedure of placing the ultrasound probe. The intensity and complexity measures are greater for new code than the reference service code. The RUC agreed that the recommended work value of 2.80 was appropriate.

The RUC recommends a work relative value of 2.80.

Practice Expense Recommendations
There are no direct practice expense inputs, as this is an add-on code performed in a facility setting.

Peripheral Vascular Rehabilitation (TAB L)
Presenters: James Maloney, MD and Alan Hirsch, MD

Work Relative Value Recommendations
New code 93668 *Peripheral arterial disease vascular rehabilitation, per session* describes supervised, treadmill based programs of progressive limb exercise, with a subsequent transition to a home-based exercise prescription. This service is intended to treat patients with intermittent claudication, patients recovering from peripheral vascular surgeries or from peripheral angioplasty/stenting procedures. Currently, CPT does not contain an existing CPT code that accurately describes therapeutic vascular rehabilitation.

The RUC evaluated the survey results for new code 93668 *Peripheral arterial disease vascular rehabilitation, per session* and agreed that there was no physician work.

Practice Expense Recommendations
The RUC recommends that there are direct inputs for this service when performed in a non-facility setting. Specifically, the RUC recommends 20 minutes of RN/Exercise physiologist time for this service.

TAB M

Small Bowel Transplantation
The RUC requests that these services be carrier priced for one year to allow the specialty society to present survey data to the RUC in February 2001. The RUC will forward recommended relative values to HCFA for consideration for the 2002 Medicare Physician Payment Schedule.

Lymph Node Biopsy
Through the CPT Process (CPT/HCPAC Advisory Committee review), The CPT Editorial Panel will be implementing a CPT-5 recommendation to delete the "separate

procedure" designation from the code descriptor nomenclature and replace this designation with cross-references identifying specific services for which the code should not be separately reported. The two services listed below are the first to undergo this revision and have a corresponding cross-reference included. As the CPT Editorial Panel proceeds with this project, it is the intention that the RUC will review these changes to recommend to HCFA that they are indeed editorial or if the change (via inclusion or exclusion of certain codes in the cross-reference) is not editorial.

The RUC recommends that the replacement of "separate procedure" in the descriptor of codes 38500 and 38530 with the addition of new explanatory notes is editorial and not a change in the service. The RUC recommends no change in the current work relative values for these services.

Photon Beam Treatment Delivery
There is currently two existing codes to describe photon beam treatment delivery. These codes are carrier priced and the RUC requests that they, along with the two new codes, remain carrier-priced. In addition, the specialty society agreed that none of these codes require physician work.

Ocular Function Screening
The CPT Editorial Panel approved a new code for ocular function screening. The specialty society has informed the RUC that these services require no physician work and will not be covered by Medicare as they are screening services.

Subcommittee Reports
At this meeting, the RUC chose to place all Subcommittee reports on a "consent calendar" and extracted items for discussion. The Subcommittee chairs did not make formal presentations of their reports.

IX. Practice Expense Advisory Committee (PEAC) Report

Doctor Bill Moran presented the PEAC report. Doctor Moran explained that the PEAC has made significant progress during its meetings through its E/M workgroup and the establishment of standardized specialty supply and time packages. It is believed that the utilization of these types of building block approaches to the refinement of direct inputs will facilitate a more efficient means of providing HCFA with recommendations at subsequent PEAC meetings. Doctor Moran explained that the PEAC has asked each specialty to develop specific supply and time packages for groups of codes and informed the RUC that a pre-service clinical labor time workgroup had been established for the development of a pre-service time package to be presented at the next meeting. Doctor Moran informed the RUC that the PEAC had established a methodology of selecting codes for refinement and explained that specialties will review the direct inputs individually and the specialty recommendations will be assigned to several PEAC members who will lead the discussions for their assigned codes. The recommendations will be sent to PEAC members a month or more prior to the October meeting for their review.

The PEAC report was approved by the RUC without any modifications.

The RUC agreed that there are several standardization and packaging issues that still need to be addressed by the PEAC. Accordingly, the RUC recommends that HCFA considers the RUC recommendations on practice expense inputs "interim" until the PEAC considers and the RUC approves issues such as standardized clinical staff times.

These issues include:
1. Pre-service staff time packages
2. Level of clinical personnel (RN/LPN/MA/Tech) blend
3. Chaperon adjustments or other add on increments to the standardized E/M clinical staff time
4. Consent time for support personnel
5. Telephone call standards
6. Supply packing issues
7. Equipment packages
8. Equipment issues (special tables, defibrillators, etc)

After the PEAC approaches to such issues have been established, staff will return any interim code practice expense recommendations back to the RUC, with potential adjustments identified for reconsideration.

X. **Administrative Subcommittee Report**

The following issues were extracted from the Administrative Subcommittee report for discussion.

The Five-Year review consent calendars were amended as follows:

- Ms. Sherry Smith noted that code 43638 was added to consent calendar one in error. The Administrative Report should be changed to read, "The American Society of General Surgeons has withdrawn their comments related to code 34001 *Removal of artery clot*. This code will be added to the consent calendar "the RUC recommends no change in RVU's."
- Doctor Zwolak requested that a list of codes included in the Society of Vascular Surgeons comment letter to HCFA be added to the consent calendar "codes to be referred to the CPT Editorial Panel." Doctor Paul Rudolf agreed this would be appropriate. The RUC approved this addition to the codes referred to CPT.
- Doctor Nagel indicated that the American Academy of Orthopaedic Surgeons would like to extract CPT code 27218 from the consent calendar to retain the current value, as there was a calculation error. Doctor Nagel noted that the percent change was erroneously calculated at 9.93% by HCFA and should be 10%. Doctor Hoehn stated this would be forwarded to the appropriate Five-year review workgroup.

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

XI. **Research Subcommittee Report**

The following issues were extracted from the Research Subcommittee report for discussion.

SMS

Doctor Plummer asked for clarification regarding the SMS survey status on page three of the Research Subcommittee Report. Doctor Hoehn explained that the response rate of the survey has decreased while the cost of distributing the survey has increased. Doctor Hoehn indicated that the cost of producing and administrating the survey has significantly increased. The typographical errors in this paragraph will be corrected.

RUC Survey Instrument

Doctor McCaffree spoke against eliminating question three of the RUC survey instrument. The Research Subcommittee report had recommended that the rating of intensity of pre- intra- and post service periods shall be eliminated from the survey. Doctor Florin explained that this question was added to the survey instrument before the first Five-year review to analyze the levels of intensity in the various periods of service.

A spiked level of intensity in one time period may not indicate high intensity across the entire service. However, he argued that this information has not added much to the RUC's consideration in the past several years. Other RUC members spoke both in favor and against deletion of this question from the survey.

The RUC approved the following motion:
The Research Subcommittee should further review their recommendations to delete question three from the RUC survey instrument.

Doctor Zwolak extracted the following bullet for discussion, "The RUC will not survey the time for reference codes. Specialties should include time in the survey for reference services with references provided by the specialty society." Doctor Zwolak indicated there is some value in the survey process of requesting that respondents think about the time they spend performing the reference service code, rather than using the time on the reference service table as the definitive time for this service. He suggested that the RUC, instead consider requesting the historical RUC time to be included on the summary form.

The RUC made the following motion:

The Research Subcommittee should further review their recommendation to no longer survey physician time for reference services.

IWPUT

- Doctor Moorefield extracted bullet three as he objected to a consensus panel determination of IWPUT. The RUC could not validate these IWPUT recommendations.

- Doctor Lichtenfeld extracted all issues from the report, as he was concerned that IWPUT may not be valid methodology. The definition of IWPUT varies and there are no definitive IWPUT data available for intra-service work.

  There are many issues that need to be addressed first before utilizing this methodology.

- From the Chronology of RUC Actions, Doctor Hoehn quoted from the RUC's actions on September 27, 1997, "Intra-service intensity or IWPUT should be used only as a measure of relativity between codes or in families of codes. IWPUT is a complimentary measure and should not be used as the sole basis for ranking or the assignment of value to a service. The workgroup further observes that most formulas for the calculation of IWPUT use imputed values, there is no preferable formula."
- Doctor Florin explained that the American College of Surgeons (ACS) review identified negative IWPUT after pre/post service work was deducted from total work. The College then utilized Harvard/ Hsaio range of IWPUT to build back to total RVU's.
- Doctor Massanari stated that he was impressed with the rigor of the ACS study and that using a single expert panel within a family of codes may be acceptable. However, there are no cross-links available to assign IWPUTs across different families of codes.
- Doctor Mabry explained that the College attempted to apply a rationale approach to utilizing IWPUT and time to identify anomalies. He indicated that IWPUT is a measurement tool.
- Doctor McCaffree agreed that IWPUT is important information in reviewing RVU's, but it should not be set in stone.
- Doctor Lichtenfeld questioned whether the committee reviewed the study completed by Health Economics Research (HER). He expressed concern that the file of IWPUT provided by Jesse Levy of HCFA to ACS may be based on flawed methodology. He expressed concern regarding this file, specifically that it may be nonreproducible and contain old information.
- Doctor Sawchuck indicated that the report does not change current RUC rules. The RUC's rules regarding compelling evidence have not changed. A specialty society must still meet these requirements before a change in work RVU's may occur.
- The College repeated that their ultimate goal was to develop a better, more accurate way to measure work. RUC members responded that magnitude estimation has worked well. Others agreed that the building block/IWPUT methodology could be utilized, but not as the sole determinant of work relative values.

The RUC made the following motion:

The RUC reaffirms its action on intensity of September 27, 1997 and allows intra-service intensities and times to be developed by surveys or a consensus panel and be presented as relative intra-service work per unit time numbers. The use of this information in no way changes the current RUC policies regarding the use and interpretation of IWPUT information.

Doctor Lichtenfeld expressed concern regarding the first bullet on page 3, which states "The original Harvard preservice RVW formula with two levels of intensity; .0224 for evaluation and .0081 for scrub should be used." Doctors' Florin and Mabry explained that these intensities are historical and were obtained from the Hsaio study.

However, the RUC agreed there is not enough information to affirm that these levels of intensities are acceptable. RUC members agreed that intensities should not be set in stone and considered validated at this time.

The RUC approved the following motion:

To delete the bullet "The original Harvard preservice RVW formula with two levels of intensity; .0224 for evaluation and .0081 for scrub should be used" from the Research Subcommittee Report.

Concern was also expressed regarding the second bullet on page 3 of the Research Subcommittee report, which states, "Only the preservice time for the categories of evaluation and scrub/dress that are developed by surveys should be used in calculating the pre-service RVW's."

The RUC approved the following motion:

To delete the bullet "Only the preservice times for the categories of evaluation and scrub/dress that are developed by surveys should be used in calculating pre-service RVW's" from the Research Subcommittee Report.

Doctor Mabry asked for clarification regarding the pathway for ACS to approach the Five-Year review based on the RUC's actions. Doctor Hoehn explained that the RUC's actions did not preclude the College from using their approach and that the RUC will require compelling evidence to recommend a change in work values.

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

XII. Practice Expense Subcommittee Report

The following issues were extracted from the Practice Expense Subcommittee report for discussion.

Doctor McCaffree expressed concern regarding the third paragraph, which states, "If the data was not supplied by the specialties involved, the default office visit level would be 99213, the level HCFA's contractor used originally to calculate current HCFA physician time."

Sherry Smith explained that the practice expense has a huge task of reviewing missing level of E/M information. In instances where specialty societies have not provided the level of E/M service, instead of holding out indefinitely for the specialty to provide the necessary information, the RUC will add in a level 99213.

The Practice Expense Subcommittee report was approved without modification and is attached to these minutes.

XIII. **Health Care Professionals Advisory Committee Report**

The RUC Health Care Professionals Advisory Committee report was approved without modification and is attached to these minutes.

XIV. **Other Issues**

Doctor Hoehn requested that all specialty societies review their survey data and RUC recommendations for conciseness, accuracy and completeness prior to submission to the RUC. He also indicated that all specialty societies that have additional practice expense data should send the data to Sherry Smith one week after the conclusion of this meeting so that it may be forwarded to HCFA.

Multi-Specialty Points of Comparison (MPC)
Doctor Hoehn established the MPC workgroup which consists of the following RUC members:

Charles Koopmann, Jr., MD (Chair)
William Gee, MD
J. Leonard Lichtenfeld, MD
David McCaffree, MD
David Regan, MD
Robert Zwolak, MD
Stephen Bauer, MD (Advisor)
Jerilynn S. Kaibel, DC (HCPAC)

Doctor Hoehn stated that the workgroup should meet to begin discussion on Multi-Specialty Points of Comparison.

Doctor Hoehn expressed a heart felt thanks to all the RUC members for all their hard work at this meeting.

The meeting adjourned at 11:30 a.m. Sunday, April 30, 2000.