JUNE 92

RUC RECOMMENDATIONS

American Medical Association
Physicians dedicated to the health of America

Grant V. Rodkey, MD
Chairman
AMA/Specialty Society RVS
Update Committee

515 North State Street
Chicago, Illinois 60610

312 464-4726
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July 7, 1992

William Toby, Jr.
Acting Administrator
Health Care Financing Administration
6325 Security Blvd.
700 E. Highrise
Baltimore, MD 21207

Dear Mr. Toby:

It is my pleasure to submit the following recommendations of the AMA/Specialty Society RVS Update Committee (RUC). These recommendations, presented in Table 1, address relative physician work values for the Medicare RBRVS for 253 new or revised codes to be included in the 1993 edition of Physicians' Current Procedural Terminology (CPT). They reflect decisions made at the May 30-31 and June 25-28 meetings of the RUC. The vast majority of these codes originated at the May 8-10 CPT Editorial Panel Meeting and were addressed by the RUC in June. I believe that this timetable demonstrates the RUC's ability to respond quickly to all coding developments.

The RUC was formed in November of 1991 and grew out of a series of discussions with major national medical specialty societies. Prior to and after the formation of the RUC, AMA staff have met with senior HCFA staff to assist us in designing an RVS update process that would best meet HCFA's needs.

The RUC is comprised of 26 members. Twenty two are representatives of major specialty societies. The remaining members represent the American Medical Association, the American Osteopathic Association, and the CPT Editorial Panel. I was appointed Chairman of the RUC by the AMA. Appendix 1 lists the current members of the RUC and their affiliations.

The work of the RUC is supported by an Advisory Committee (AC) made up of representatives of all 85 specialty societies in the AMA House of Delegates. Each AC member is asked to designate a specialty society RVS Committee. These committees generate the recommendations presented to the RUC by each relevant AC member.

The RUC operates under formal documents outlining its Structure and Functions and Rules and Procedures. These are attached as Appendix 2. In addition, the RUC adopted a methodology for the first year of its work. This methodology, together with its organizing documents, is designed to produce relative work values that are consistent with the

current Medicare RBRVS, can be integrated into HCFA's RBRVS refinement efforts, reflect standard protocols across specialty societies, and have high face validity. The best description of the current method can be found in a sample of the survey instrument provided to participating specialty societies. This is Appendix 3.

The following brief review of the RUC process and method will be helpful as you consider our recommendations.

1. The CPT Editorial Panel adds new codes or revises current codes at one of its meetings. This information is transmitted to the RUC.

2. The RUC staff, in close cooperation with CPT staff, summarize Editorial Panel actions and transmit this information to the AC. AC members indicate their level of interest in each code (i.e., develop a formal recommendation, comment on recommendations, no interest, or coding change should not change physician work).

3. RUC staff work with AC members and their specialty society to develop a customized survey instrument for use in a magnitude estimation of codes of interest. This instrument uses reference services identified by the AC member and provides the full descriptor of each code under study. (See Appendix 3.)

4. The AC member works with his specialty society's RVS Committee to administer the survey. In general, the survey is first completed by mail by the society's RVS Committee, which then meets to review the median values for each code, and adjusts these results as warranted by a detailed clinical discussion of the results. This small group survey method reflects Phase III of the Hsiao study.

5. The AC member forwards the specialty's recommendations to the RUC. Multiple societies and specialties developing recommendations for the same code are encouraged to collaborate early in this process.

6. AC recommendations are sent to RUC members and commenting AC members prior to the meeting of the RUC. These recommendations document the methods used in developing the recommendation, summarize survey data, and indicate key reference services.

7. The RUC considers specialty recommendations and comments in an open meeting. It votes on each recommendation, with a 2/3 vote required for acceptance. If it does not accept a recommendation, it refers it to the originating AC member and to a facilitation committee, which returns with a recommendation for consideration.

In the case of multiple recommendations, the RUC may either accept one of the recommendations or refer them to a facilitation committee for resolution. In most instances, specialties agreed on a consensus recommendation to the RUC.

Through this method, the RUC was able to dispose of all items of business that it has considered. As indicated in Table 1, the RUC took the following actions:

- No recommendation made, code revision will not alter work.
- Revised code surveyed, code revision will not alter work.
- Recommended change in value for revised code.
- Recommended value for new code.
- Interim recommended value, full RUC review for next cycle.
- Recommendation in the form of a ratio to a current code.
- No recommendation at this time given available data.

I would like to underscore several points about the RUC process.

- The RUC accepts the Medicare RBRVS as its framework, while recognizing that the RBRVS is undergoing refinement.

- The process adapts both the Harvard RBRVS and HCFA refinement methods to the needs and requirements of RVS updating.

- The RUC, like HCFA, uses reference services to value services. For the RUC, reference services are specialty specific and serve as a ruler against which to evaluate each new or revised code. Thus, although a key reference service used to value a code may have a similar value, it often does not.

- The RUC process is extremely open. The RUC itself provides broad representation of the medical profession. The AC includes many more specialties and societies.

- The RUC is committed to due process. Due to the severe time constraints this year, it attempted to resolve all disagreements at the June meeting through the use of facilitation committees at that same meeting. Although this approach was quite successful, in the future, the RUC intends to implement a more formal reconsideration process.

- The key to the methodology is review during RUC meetings. RUC members subject each recommendation to exacting scrutiny. Methods and clinical comparisons undergo rigorous review and AC members must defend every aspect of their recommendations. The RUC does not hesitate to refer a recommendation back to the specialty or to a facilitation committee.

The RUC's recommendations are summarized in Table 1. This table contains each new or revised CPT code for which the RUC is making a recommendation. A large number of revised codes not listed have been identified by AC members as not requiring a reevaluation of physician work. In addition, as evidenced by a number of our recommendations, the RUC adopted as a general principle that minor wording changes to an existing code should not be the occasion for change in the relative work value for that code. Table 1 contains the following information:

Column 1: Internal RUC tracking number. (Omitted numbers were assigned to codes not requiring a recommendation.)

Column 2: CPT code. (Code numbers are subject to minor revisions prior to finalization of CPT 1993.)

Column 3: Descriptor for new or revised code. (Descriptors subject to minor revision prior to finalization of CPT 1993.).

Column 4: Global period. (Based on information supplied by HCFA).

Column 5: Recommended relative work value. (Where no recommendation is indicated, see Column 8 for reasons (i.e., "no change in work" for revised code or "no recommendation at this time" for new codes). Also, several recommendations are expressed as ratios to existing codes to reflect HCFA's refinement process and specialty concerns with existing values.

Column 6: Key reference service. (As indicated by recommending AC member(s) and/or RUC review. Note that the RUC does not focus on equivalence to reference services.)

Column 7: Specialty Societies making recommendation(s).

Column 8: Comments. (These include the basis for the RUC recommendation as well as any special considerations. Where relevant, it also indicates, by Attachment number, specialty documentation supporting the RUC recommendation.)

Mr. Toby, I am confident that the Health Care Financing Administration will find these recommendations extremely useful as it prepares its regulations for the 1993 Medicare Fee Schedule. We have been informed by HCFA staff that our submission will be timely for planned HCFA review activities. We have expended considerable resources to complete and submit these recommendations on this schedule.

Based on what all involved consider an extraordinarily successful first year, the RUC is proceeding with plans to develop recommendations for new or revised codes for CPT 1994. In preparation for these efforts, the RUC will proceed with refinements to its process and methods, and will explore ways in which it can assist HCFA with the ongoing maintenance of the RBRVS. It will also implement a Health Care Professionals Advisory Committee to include all relevant non-MD/DO health professions. We would be pleased to consult with HCFA on the composition of this committee. Finally, I would welcome the opportunity to consult with you and your staff on any other ways in which our efforts can best complement yours.

If you have questions about any element of this submission, please contact Dorothy J. Moss (202-789--7411) of the AMA.

Sincerely,

Grant

Grant V. Rodkey, MD

GVR/mjs

cc: James S. Todd, MD

Attachments

American Medical Association
Physicians dedicated to the health of America

James S. Todd, MD
Executive Vice President

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July 7, 1992

Louis W. Sullivan, MD
Secretary of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Dear Doctor Sullivan:

It is my pleasure to provide you with a copy of the first annual recommendations of the AMA/Specialty Society RVS Update Committee (RUC). These recommendations were transmitted by the Chairman of the RUC, Grant V. Rodkey, MD to Mr. William Toby, Jr. on July 6. They address relative work values for the new Medicare RBRVS for 253 new or revised codes to be included in the 1993 edition of Physicians' Current Procedural Terminology (CPT). These recommendations reflect decisions at the May 30-31 and June 25-28 meetings of the RUC and are summarized in Table 1 of Doctor Rodkey's letter to Mr. Toby.

The RUC was formed in November of 1991 and grew out of a series of discussions with major national medical specialty societies. Prior to and after the formation of the RUC, AMA staff have met with senior HCFA staff to assist us in designing an RVS update process that would best meet HCFA's needs.

The RUC has 26 members. Twenty two are representatives of major specialty societies. The remaining members represent the American Medical Association, the American Osteopathic Association, and the CPT Editorial Panel. Grant V. Rodkey, MD has been appointed Chairman.

The RUC's work is supported by an Advisory Committee (AC) made up of all 85 specialty societies in the AMA House of Delegates. Each AC member is asked to designate a specialty society RVS Committee. These committees generate recommendations sent to the RUC by each relevant AC member.

The RUC operates under formal documents outlining its Structure and Functions and Rules and Procedures. In addition, it has adopted a methodology designed to produce relative work values that are consistent with the current Medicare RBRVS, can be integrated into HCFA's RBRVS refinement efforts, reflect standard protocols across specialty societies, and have high face validity.

The RUC process can be summarized as follows. First, the CPT Editorial Panel adds new codes or revises current codes. Second, this information

is transmitted to the RUC, which forwards a summary to all AC members, who indicate their level of interest in each code. Third, AMA staff work with AC members to develop a survey instrument for use with each code of interest. Fourth, AC members work with their specialty society RVS Committees to administer the survey. Fifth, the AC members forward recommendations to the RUC. (Coordination among AC members at this stage is strongly encouraged. Joint proposals among AC members who have chosen to survey is desired, although not requisite.) Sixth, AC recommendations are sent to RUC members and interested AC members prior to the meeting of the RUC. Seventh, the RUC considers specialty recommendations and comments in an open meeting. A 2/3 vote is required for acceptance. A facilitation committee process is available for recommendations not accepted as presented. Through this method, the RUC disposed of all items of business before it.

I would like to underscore several points about the RUC process. The RUC accepts the Medicare RBRVS as its framework, while recognizing that the RBRVS is undergoing refinement. Thus, it has adapted both the Harvard RBRVS and HCFA refinement methods to the needs and requirements of RVS updating. In addition, its process is extremely open and committed to due process. Finally, the key to the RUC methodology is exacting clinical and methodological review by RUC members during their meetings.

Mr. Secretary, I am confident that HCFA will find these recommendations extremely useful as it prepares its regulations for the 1993 Medicare Fee Schedule. We have been informed by HCFA staff that our submission will be timely. As you can imagine, we have expended considerable resources to complete and submit these recommendations on this schedule. Indeed, the vast majority of these codes originated at the May 8-10 CPT Editorial Panel Meeting and were addressed by the RUC in June.

Based on an extraordinarily successful first year, the RUC is proceeding with plans to develop recommendations for 1994. It is refining its process and methods, and will explore ways in which it can assist HCFA with the ongoing maintenance of the RBRVS. It will also implement a Health Care Professionals Advisory Committee to include all relevant non-MD/DO health professions. We intend to work closely with HCFA staff in an effort to best complement their activities. I will continue to keep you abreast of our progress and look forward to your input into this important project.

In closing, I want to underscore that the American Medical Association is fully committed to devote the resources necessary to make the RUC process a continuing success. We view this new endeavor as a milestone in our relationship with both the federal government and the national medical specialty societies.

Sincerely,

James S. Todd, MD

JST/mjs

cc: Grant V. Rodkey, MD

Attachments

American Medical Association
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Grant V. Rodkey, MD
Chairman
AMA/Specialty Society RVS
Update Committee

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Memo to: AMA/Specialty Society RVS Update Committee

From: Grant V. Rodkey, MD Grant

Date: July 8, 1992

Subject: Recommendations Submitted to HCFA

It is with a great deal of pleasure that I enclose for your information a copy of the first annual RUC recommendations for physician work relative values for new and revised CPT codes. These recommendations were submitted to the Acting HCFA Administrator, Mr. William Toby, Jr., on July 6. Doctor Todd also forwarded a copy of your recommendations to Louis W. Sullivan, MD, Secretary of HHS. Attached you will find copies of these letters, along with a table listing the recommendations for each CPT code. As the table indicates, the ballot on the two new codes for "intravascular stent placement, each additional vessel," passed by the required two-thirds majority. We have not duplicated the appendices and attachments for you since they replicate materials distributed at the May and June RUC meetings. Copies of the attachments are available upon request by calling Robin Russell at the AMA (312-464-4736).

I believe that we can all feel very proud of these recommendations. Despite an extremely compressed timetable for this cycle, the RUC members, Advisory Committee members, and AMA and specialty society staff were able to develop and approve recommendations for 253 codes to be included in CPT 1993. In so doing, we demonstrated to both the medical profession and the government that the AMA/Specialty Society RVS Update Process can effectively represent the profession in maintaining and updating the Medicare RBRVS.

Although we recognize that you will want to share these materials with others in the leadership of your specialty, I must ask you to refrain from distributing them widely. Information on new and revised CPT codes is confidential and proprietary and, like the relative values, is subject to change before finalization.

Finally, as we discussed, the next meeting of the RUC will be held on November 20-22, 1992, in Chicago at the Stouffer Riviere (tentative). The meeting will begin at 8:00 am on Friday, so you should plan to arrive by Thursday evening, and will conclude by 12:00 noon on Sunday.

Attachments

cc: James S. Todd, MD
Barry S. Eisenberg
Mark J. Segal, PhD
Sandra L. Sherman
Specialty Staff Contacts

REVISED 7/7/92

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS

TABLE 1:
RECOMMENDATIONS FOR PHYSICIAN WORK RELATIVE VALUE UNITS (RVUs) FOR NEW AND REVISED CPT CODES FOR CPT 1993

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
100	00534•	Anesthesia for insertion or replacement of cardioverter/defibrillator		7 Base Units	00520 00528 00530 00540 00560 00632 00790 00844 00857 00872 00912 01920 01921 01922	ASA	ASA recommendation accepted See Attachment 1
101	10140	Incision and drainage of hematoma, ~~†simple~~ seroma or fluid collection	010	no change		ASPRS	CPT revision did not alter work of service

†A glossary of specialty society society acronyms may be found at the end of Table 1.

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
106	11101	Biopsy of skin, subcataneous tissue and/or mucous membrance (including simple closure), unless otherwise listed (separate procedure); each separate/additional lesion	ZZZ	no change		ASPRS	CPT revision did not alter work of service
107	11200	~~Excision (including simple closure or ligature strangulation)~~ Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	010	no change		ASPRS	CPT revision did not alter work of service
108	11201	~~Excision (including simple closure or ligature strangulation)~~ Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions	ZZZ	no change		ASPRS	CPT revision did not alter work of service
109	11300•	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	000	.73	11400	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
110	11301•	Shaving of epidermal or dermal lesion, single lesion,trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	000	1.07	11401	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
111	11302•	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	000	1.32	11402	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
112	11303•	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	000	1.57	11403	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
113	11305•	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	000	.85	11420	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
114	11306•	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	000	1.25	11421	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
115	11307•	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	000	1.44	11422	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
116	11308•	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	000	1.78	11423	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
117	11310•	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	000	.92	11440	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
118	11311•	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	000	1.32	11441	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
119	11312•	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	000	1.53	11442	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
120	11313•	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	000	2.06	11443	ASPRS AAD	Recommendation reflects RUC evaluation of ASPRS and AAD recommendations resulting in a value that is 80% of the key reference service
121	11450	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with ~~primary closure~~ simple or intermediate repair	090	no change		ASPRS	CPT revision did not alter work of service
122	11451	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with ~~other~~ complex ~~closure~~ repair	090	4.00		ASPRS	Increased from current value to reflect nature of coding change
123	11462	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with ~~primary closure~~ simple or intermediate repair	090	no change		ASPRS	CPT revision did not alter work of service
124	11463	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with ~~other~~ complex ~~closure~~ repair	090	4.00		ASPRS	Increased from current value to reflect nature of coding change
125	11470	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with ~~primary closure~~ simple or intermediate repair	090	no change		ASPRS	CPT revision did not alter work of service

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
126	11471	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with ~~other~~ complex ~~closure~~ repair	090	4.50		ASPRS	Increased from current value to reflect nature of coding change
127	11975	Insertion, ~~or reinsertion,~~ implantable contraceptive capsules	XXX	1.50	58300	ACOG	ACOG recommendation accepted See Attachment 2a
128	11976	Removal, ~~without reinsertion,~~ implantable contraceptive capsules	XXX	1.80	24200 20670 11971	ACOG	Recommendation reflects RUC evaluation of ACOG recommendation
129	11977•	Removal with reinsertion, implantable contraceptive capsules	XXX	3.30	11975 11976	ACOG	Recommendation reflects the sum of 11975 and 11976
132	16040•	Excision burn wound, without skin grafting, employing alloplastic dressing (eg, synthetic mesh), any anatomic site; less than 1% total body surface area	000	.96	11041 16010	ASPRS	RUC accepted revised ASPRS recommendation (Assumption of global period 000 key in assigning work RVUs since no follow-up care is included)
133	16041•	Excision burn wound, without skin grafting, employing alloplastic dressing (eg, synthetic mesh), any anatomic site; greater than 1% and less than 9% total body surface area	000	2.48	16015	ASPRS	RUC accepted revised ASPRS recommendation (Assumption of global period 000 key in assigning work RVUs since no follow-up care is included)

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
134	16042•	Excision burn wound, without skin grafting, employing alloplastic dressing (eg, synthetic mesh), any anatomic site; each additional 9% total body surface area, or part thereof (For debridement, curettement of burn wound, see 16010-16030)	000	2.48	16015 16041	ASPRS	RUC accepted revised ASPRS recommendation (Assumption of global period 000 key in assigning work RVUs since no follow-up care is included)
135	17105	Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthesia; complicated or extensive lesions~~(s)~~	010	no change		ASPRS	CPT revision did not alter work of service
136	17250	Chemical cauterization of ~~wound~~ granulation tissue (proud flesh, sinus or fistula)	000	no change		ASPRS	CPT revision did not alter work of service
137	19240	Mastectomy, modified radical, including axillary lymph nodes, with or without ~~and~~ pectoralis minor muscle, but excluding pectoralis major muscle	090	no change		ASPRS	CPT revision did not alter work of service
138	19290•	Preoperative placement of needle localization wire, breast	000	1.25		SCVIR ACR	Recommendation based on RUC evaluation of SCVIR and ACR recommendations
139	19291•	Preoperative placement of needle localization wire, breast; each additional lesion	ZZZ	.63	19290	SCVIR ACR	Recommendation assumes each lesion at 50% of primary procedure

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
313	21336•	Open treatment of nasal septal fracture, with or without stabilization	090	6.00	19318 14060 21453 21493	ASPRS AA0-HNS	ASPRS recommendation accepted See Attachment 3
317	21344•	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	090	19.42	62010	ASPRS AA0-HNS	Reflects RUC evaluation of ASPRS and AAO-HNS recommendations
320	21348•	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation; with bone grafting (includes obtaining graft)	090	20.00	15946	ASPRS AAO-HNS	ASPRS recommendation accepted See Attachment 3
322	21356•	Open treatment of depressed zygomatic arch fracture (eg, Gilles approach)	010	5.37	21325 21330 21360	ASPRS AAO-HNS	AAO-HNS recommendation accepted See Attachment 4
325	21366•	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod, with internal fixation and multiple surgical approaches; with bone grafting (includes obtaining graft)	090	17.5	20900 20902 21360 21365 21255 21247	ASPRS AAO-HNS	AAO-HNS recommendation accepted See Attachment 4
327	21408•	Open treatment of fracture of orbit, except "blowout"; without implant; with bone grafting (includes obtaining graft)	090	15.00	21433 21267	AAO ASPRS AAO-HNS	AAO/ASPRS/AAO-HNS consensus on AAO recommendation accepted See Attachment 5a

**The actual recommendation is the ratio to the key reference service. The number in parentheses, provided for information only, is this ratio multiplied by the 1992 work RVUs assigned to the key reference service. Where two reference services are indicated, this number is the unweighted average of the product of each ratio multiplied by the 1992 work RVUs of its reference service (see p. 6, Attachment 6).*

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
330	21423•	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches	090	15.5	21422 21433 21365 21366	ASPRS AAO-HNS	AAO-HNS recommendation accepted See Attachment 4
335	21436•	Open treatment of craniofacial separation (LeFort III type) with wiring and/or internal fixation; complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	090	24.00	15946	ASPRS AAO-HNS	ASPRS recommendation accepted See Attachment 3
341	21453	Closed treatment of mandibular fracture ~~with manipulation~~ with interdental fixation	090	6.35	13152 15937	ASPRS	ASPRS recommendation accepted See Attachment 3
347	21485	Closed treatment of temporomandibular dislocation; complicated, ~~manipulative treatment~~ (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	090	6.35	21485 13152	ASPRS	ASPRS recommendation accepted See Attachment 3
348	21493	Closed treatment ~~closed or open~~ hyoid fracture; without manipulation	090	no change	21493	ASPRS	CPT revision did not alter work of service
363	23616•	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(-ies); with proximal humeral prosthetic replacement	090	(20.94)* 1.23 X 23470	23470	AAOS	AAOS recommendation accepted as qualified See Attachment 6
1	24006•	Arthrotomy of the elbow, with capsular excision for capsular release (separate procedure)	090	(10.33)* 1.30 x 24102	24102	AAOS	AAOS recommendation accepted as qualified See Attachment 6

**The actual recommendation is the ratio to the key reference service. The number in parentheses, provided for information only, is this ratio multiplied by the 1992 work RVUs assigned to the key reference service. Where two reference services are indicated, this number is the unweighted average of the product of each ratio multiplied by the 1992 work RVUs of its reference service (see p. 6, Attachment 6).*

Final assignments of code numbers and descriptors are subject to change by the CPT Editorial Panel prior to publication of the 1993 book.

Tracking Number	Code (● new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
368	24505	Closed treatment of ~~closed~~ humeral shaft fracture; with manipulation, with or without skeletal traction	090	(4.60)* .40 X 24515	24515	AAOS	AAOS recommendation accepted as qualified See Attachment 6
371	24515	Open treatment of ~~closed or open~~ humeral shaft fracture with ~~or without internal or external skeletal fixation~~ plate/screws, with or without cerclage	090	(11.51)* 1.00 X 24515	24515	AAOS	AAOS recommendation accepted as qualified See Attachment 6
372	24516●	Open treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws	090	(11.51)* 1.00 X 24515	24515	AAOS	AAOS recommendation accepted as qualified See Attachment 6
380	24545	Open treatment of ~~closed or open~~ humeral supracondylar or transcondylar fracture, with or without internal or external ~~skeletal~~ fixation; without intercondylar extension	090	(10.17)* .79 X 24545	24545	AAOS	AAOS recommendation accepted as qualified See Attachment 6
381	24546●	Open treatment of ~~closed or open~~ humeral supracondylar or transcondylar fracture, with or without internal or external ~~skeletal~~ fixation; with intercondylar extension	090	(15.45)* 1.21 X 24545	24545	AAOS	AAOS recommendation accepted as qualified See Attachment 6
405	25520●	Closed treatment of radial shaft fracture with dislocation of distal radio-ulna joint (Galeazzi fracture/dislocation)	090	(6.34)* .91 X 24620	24620	AAOS	AAOS recommendation accepted as qualified See Attachment 6
406	25525●	Open treatment of radial shaft fracture with internal and/or external fixation and closed treatment of dislocation of distal radio-ulna joint (Galeazzi fracture/dislocation) with or without percutaneous skeletal fixation	090	(12.32)* .94 X 24635	24635	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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407	25526•	Open treatment of radial shaft fracture with internal and/or external fixation and open treatment with or without internal or external fixation of distal radio-ulna joint (Galeazzi fracture/dislocation) includes repair of triangular cartilage	090	(18.49)* 1.41 X 24635	24635	AAOS	AAOS recommendation accepted as qualified See Attachment 6
410	25574•	Open treatment of radial and ulnar shaft fractures; with internal or external fixation; of radius or ulna	090	(6.36)* .65 X 25575	25575	AAOS	AAOS recommendation accepted as qualified See Attachment 6
411	25575	Open treatment of radial and ulnar shaft fractures; with internal or external fixation; of radius and ulna	090	(9.99)* 1.02 X 25575	25575	AAOS	AAOS recommendation accepted as qualified See Attachment 6
301	25605	Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation	090	(5.63)* 1.14 X 25605 1.14 X 25610	25605 25610	AAOS	AAOS recommendation accepted as qualified See Attachment 6
420	26608•	Percutaneous skeletal fixation of metacarpal fracture, each bone	090	(5.40)* 1.00 X 26607	26607	AAOS	AAOS recommendation accepted as qualified See Attachment 6
422	26650	Percutaneous skeletal fixation ~~Treatment of closed~~ of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with skeletal fixation	090	(5.46)* .73 X 26665	26665	AAOS	AAOS recommendation accepted as qualified See Attachment 6
443	27193•	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation	090	(5.31)* .46 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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445	27194•	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia	090	(6.08)* .53 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6
453	27215•	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s) (ie, pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation	090	(9.86)* .85 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6
454	27216•	Treatment of posterior pelvic ring fracture and/-or dislocation with percutaneous skeletal fixation, (includes ilium, sacroiliac joint and/or sacrum)	090	(22.77)* 1.97 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6
455	27217•	Open treatment of anterior ring fracture and/or dislocation with internal fixation, (includes pubic symphysis and/or rami)	090	(18.22)* 1.58 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6
456	27218•	Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)	090	(26.11)* 2.26 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6
459	27226•	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation	090	(19.73)* 1.71 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6
460	27227•	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation	090	(37.95)* 3.29 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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461	27228•	Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture; with internal fixation	090	(60.71)* 5.26 X 27222	27222	AAOS	AAOS recommendation accepted as qualified See Attachment 6
469	27244	Open treatment of basilar neck, ~~closed or open~~ intertrochanteric, pertrochanteric or subtrochanteric femoral fracture; with ~~internal fixation~~ plate/screw type implant, with or without cerclage	090	(14.32)* .94 X 27244	27244	AAOS	AAOS recommendation accepted as qualified See Attachment 6
470	27245•	Open treatment of basilar neck, ~~closed or open~~ intertrochanteric, pertrochanteric or subtrochanteric femoral fracture; with an intramedullary implant, with or without interlocking screws and/or cerclage	090	(18.68)* 1.23 X 27244	27244	AAOS	AAOS recommendation accepted as qualified See Attachment 6
471	27254	Open treatment of ~~closed or open~~ hip dislocation, traumatic, with acetabular ~~hip fixation,~~ wall and femoral head fracture, with or without internal or external ~~skeletal~~ fixation	090	(18.22)* 1.44 X 27253	27253	AAOS	AAOS recommendation accepted as qualified See Attachment 6
473	27256	Treatment of spontaneous hip dislocation (developmental, including congenital or pathological), by abduction splint or traction; any method	090	(4.92)* .97 X 27257	27257	AAOS	AAOS recommendation accepted as qualified See Attachment 6
479	27496•	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);	090	(5.28)* 1.00 X 27600 1.00 X 27601	27600 27601	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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480	27497•	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/-or nerve	090	(9.23)* 1.75 X 27600 1.75 X 27601	27600 27601	AAOS	AAOS recommendation accepted as qualified See Attachment 6
481	27498•	Decompression fasciotomy, thigh and/or knee, multiple compartments;	090	(10.55)* 2.00 X 27600 2.00 X 27601	27600 27601	AAOS	AAOS recommendation accepted as qualified See Attachment 6
482	27499•	Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve	090	(14.51)* 2.75 X 27600 2.75 X 27601	27600 27601	AAOS	AAOS recommendation accepted as qualified See Attachment 6
483	27500	Closed treatment of ~~closed~~ femoral shaft fracture; ~~including supracondylar~~ without manipulation ~~(includes traction)~~	090	(5.90)* .59 X 27502	27502	AAOS	AAOS recommendation accepted as qualified See Attachment 6
484	27501•	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation	090	(5.90)* .59 X 27502	27502	AAOS	AAOS recommendation accepted as qualified See Attachment 6
486	27503•	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension; with manipulation, with or without skin or skeletal traction	090	(9.33)* 1.70 X 27508	27508	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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489	27506	Open treatment of ~~closed or open~~ femoral shaft fracture ~~(including supracondylar)~~, with or without ~~internal or~~ external ~~skeletal~~ fixation with insertion of intramedullary implant, with or without cerclage and/or locking screws	090	(16.79)* 1.03 X 27506	27506	AAOS	AAOS recommendation accepted as qualified See Attachment 6
490	27507●	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	090	(13.54)* .83 X 27506	27506	AAOS	AAOS recommendation accepted as qualified See Attachment 6
492	27509●	Percutaneous skeletal fixation of supracondylar or transcondylar femoral fracture with or without intercondylar extension	090	(7.14)* 1.30 X 27508	27508	AAOS	AAOS recommendation accepted as qualified See Attachment 6
494	27511●	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, with or without internal or external fixation	090	(13.18)* 2.40 X 27508	27508	AAOS	AAOS recommendation accepted as qualified See Attachment 6
496	27513●	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension with or without internal or external fixation	090	(17.68)* 3.22 X 27508	27508	AAOS	AAOS recommendation accepted as qualified See Attachment 6
505	27535●	Open treatment of tibial fracture, proximal (plateau); unicondylar with or without internal or external fixation	090	(9.24)* 1.29 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6
506	27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal ~~or external skeletal~~ fixation	090	(13.34)* 1.86 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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512	27558•	Open treatment of knee dislocation, with or without internal or external fixation; with primary ligamentous repair, with augmentation/-reconstruction	090	(24.97)* 1.50 X 27557	27557	AAOS	AAOS recommendation accepted as qualified See Attachment 6
517	27750	Closed treatment of ~~closed~~ tibial shaft fracture (with or without fibular fracture); without manipulation	090	(4.11)* .57 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6
518	27752	Closed treatment of ~~closed~~ tibial shaft fracture (with or without fibular fracture); with manipulation with or without skeletal traction	090	(5.13)* .71 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6
520	27756	~~Open Treatment of~~ Percutaneous skeletal fixation of ~~closed or open~~ tibial shaft fracture ~~with internal skeletal fixation; simple~~ (with or without fibular fracture) (eg, pins or screws)	090	(6.16)* .86 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6
521	27758	~~complicated~~ Open treatment of ~~closed or open~~ tibial shaft fracture, ~~with internal skeletal fixation; complicated~~ (with or without fibular fracture) with plate/screws, with or without cerclage	090	(9.24)* 1.29 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6
522	27759•	Open treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	090	(9.24)* 1.29 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6
539	27824•	Closed treatment of fracture of weight bearing articular portion of distal tibia (ie, pilon or tibial plafond), with or without anesthesia; without manipulation	090	(2.86)* 1.00 X 27816	27816	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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540	27825•	Closed treatment of fracture of weight bearing articular portion of distal tibia (ie, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation	090	(5.70)* 1.06 X 27818	27818	AAOS	AAOS recommendation accepted as qualified See Attachment 6
541	27826•	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (ie, pilon or tibial plafond), with internal or external fixation; of fibula only	090	(8.53)* .84 X 27822 .84 X 27823	27822 27823	AAOS	AAOS recommendation accepted as qualified See Attachment 6
542	27827•	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (ie, pilon or tibial plafond), with internal or external fixation; of tibia only	090	(13.65)* 1.34 X 27822 1.34 X 27823	27822 27823	AAOS	AAOS recommendation accepted as qualified See Attachment 6
543	27828•	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (ie, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula	090	(15.93)* 1.57 X 27822 1.57 X 27823	27822 27823	AAOS	AAOS recommendation accepted as qualified See Attachment 6
544	27829•	Open treatment of distal tibiofibular joint (syndesmosis) disruption with or without internal or external fixation	090	(5.12)* .50 X 27822 .50 X 27823	27822 27823	AAOS	AAOS recommendation accepted as qualified See Attachment 6
551	27892•	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve (For decompression fasciotomy of the leg without debridement, see code 27600)	090	(9.23)* 1.75 X 27600 1.75 X 27601	27600 27601	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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552	27893•	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve (For decompression fasciotomy of the leg without debridement, see code 27601)	090	(9.23)* 1.75 X 27600 1.75 X 27601	27600 27601	AAOS	AAOS recommendation accepted as qualified See Attachment 6
553	27894•	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve (For decompression fasciotomy of the leg without debridement, see code 27602)	090	(14.51)* 2.75 X 27600 2.75 X 27601	27600 27601	AAOS	AAOS recommendation accepted as qualified See Attachment 6
574	28531•	Open treatment of sesamoid fracture with or without internal fixation	090	(2.12)* 2.00 X 28530	28530	AAOS	AAOS recommendation accepted as qualified See Attachment 6
579	28576•	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	090	(3.95)* 1.29 X 28575	28575	AAOS	AAOS recommendation accepted as qualified See Attachment 6
586	28636•	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	010	(2.82)* .68 X 28645	28645	AAOS	AAOS recommendation accepted as qualified See Attachment 6
590	28666•	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation	010	(2.70)* .95 X 28675	28675	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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593	29850•	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	090	(8.39)* .64 X 27540	27540	AAOS	AAOS recommendation accepted as qualified See Attachment 6
594	29851•	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)	090	(13.04)* 1.00 X 27540	27540	AAOS	AAOS recommendation accepted as qualified See Attachment 6
595	29855•	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar with or without internal or external fixation (includes arthroscopy)	090	(9.24)* 1.29 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6
596	29856•	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)	090	(15.80)* 2.20 X 27532	27532	AAOS	AAOS recommendation accepted as qualified See Attachment 6

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140	30460●	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	090	10.00	14060 19318 42415	ASPRS	ASPRS recommendation accepted See Attachment 3
141	30462●	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	090			ASPRS	No recommendation at this time
143	31730●	Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy	000	3.00	31500	ATS STS	Recommendation reflects RUC evaluation of STS and ATS recommendations
4	33500	Repair of coronary arteriovenous or arteriocardiac chamber fistula; with cardio-pulmonary bypass	090	25.20		STS	STS recommendation accepted See Attachment 7
5	33501●	Repair of coronary arteriovenous or arteriocardiac chamber fistula; without cardio-pulmonary bypass	090	17.00		STS	STS recommendation accepted as modified at RUC meeting See Attachment 7
144	33510	Coronary artery bypass, vein only; single coronary venous graft	090	no change		STS ACC	CPT revision did not alter work of service
145	33511	Coronary artery bypass, vein only; two coronary venous grafts	090	no change		STS ACC	CPT revision did not alter work of service
146	33512	Coronary artery bypass, vein only; three coronary venous grafts	090	no change		STS ACC	CPT revision did not alter work of service
147	33513	Coronary artery bypass, vein only; four coronary venous grafts	090	no change		STS ACC	CPT revision did not alter work of service

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148	33514	Coronary artery bypass, vein only; five coronary venous grafts	090	no change		STS ACC	CPT revision did not alter work of service
149	33516	Coronary artery bypass, vein only; six or more coronary venous grafts	090	no change		STS ACC	CPT revision did not alter work of service
150	33517●	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for arterial graft)	090	2.00	92984	STS ACC	Joint STS/ACC recommendation accepted as modified Increase is set to equal value of key reference service. ACC and STS believe that the key reference service is undervalued. See Attachment 7
151	33518●	Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for arterial graft)	090	4.00	92984	STS ACC	Joint STS/ACC recommendation accepted as modified Increase is set to equal value of key reference service. ACC and STS believe that the key reference service is undervalued. See Attachment 7
152	33519●	Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (list separately in addition to code for arterial graft)	090	6.00	92984	STS ACC	Joint STS/ACC recommendation accepted as modified Increase is set to equal value of key reference service. ACC and STS believe that the key reference service is undervalued. See Attachment 7

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
153	33521•	Coronary artery bypass, using venous graft(s) and arterial graft(s);four venous grafts (list separately in addition to code for arterial graft)	090	8.00	92984	STS ACC	Joint STS/ACC recommendation accepted as modified Increase is set to equal value of key reference service. ACC and STS believe that the key reference service is undervalued. See Attachment 7
154	33522•	Coronary artery bypass, using venous graft(s) and arterial graft(s);five venous grafts (list separately in addition to code for arterial graft)	090	10.00	92984	STS ACC	Joint STS/ACC recommendation accepted as modified Increase is set to equal value of key reference service. ACC and STS believe that the key reference service is undervalued. See Attachment 7
155	33523•	Coronary artery bypass, using venous graft(s) and arterial graft(s);six or more venous grafts (list separately in addition to code for arterial graft)	090	12.00	92984	STS ACC	Joint STS/ACC recommendation accepted as modified Increase is set to equal value of key reference service. ACC and STS believe that the key reference service is undervalued. See Attachment 7

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
24	33530	Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (listed separately in addition to code for primary procedure) (Use 33530 only for codes 33400-33478; 33510-33516) (Basic procedures include endarterectomy or angioplasty)	ZZZ	12.00		STS ACC	STS/ACC consensus recommendation accepted See Attachment 7
156	33531•	Coronary artery bypass, using arterial graft(s); single arterial graft	090	1.11 x 33510	33510	STS ACC	Joint STS/ACC recommendation accepted as modified See Attachment 7
157	33532•	Coronary artery bypass, using arterial graft(s); two coronary arterial grafts	090	1.10 x 35531	33511	STS ACC	Joint STS/ACC recommendation accepted as modified Note: STS believes the increment between adjacent codes in this series should be an absolute amount rather than a ratio. See Attachment 7
158	33533•	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts	090	1.19 x 33531	33531	STS ACC	Joint STS/ACC recommendation accepted as modified Note: STS believes the increment between adjacent codes in this series should be an absolute amount rather than a ratio. See Attachment 7

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
159	33534•	Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts	090	1.29 x 33531	33531	STS ACC	Joint STS/ACC recommendation accepted as modified Note: STS believes the increment between adjacent codes in this series should be an absolute amount rather than a ratio. See Attachment 7
160	33800•	Aortic suspension (aortopexy) for tracheal decompression, eg, for tracheomalacia (separate procedure)	090	16.00		STS ACC	Joint STS/ACC recommendation accepted See Attachment 7
23a-n	35450 35452 35454 35456 35458 35459 35460 35470 35471 35472 35473 35474 35475 35476	Transluminal balloon angioplasty	000	no change		SCVIR ACC	CPT revision did not alter work of service
23o	35480•	Transluminal peripheral atherectomy, open; renal or other visceral artery	000	11.67	35471 35450	SCVIR ACC	Joint SCVIR/ACC recommendation accepted See Attachment 8

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23p	35481•	Transluminal peripheral atherectomy, open; aortic	000	8.01	35472 35452	SCVIR ACC	Joint SCVIR/ACC recommendation accepted See Attachment 8
23q	35482•	Transluminal peripheral atherectomy, open; iliac	000	7.01	35473 35454	SCVIR ACC	Joint SCVIR/ACC recommendation accepted See Attachment 8
23r	35483•	Transluminal peripheral atherectomy, open; femoral-popiteal	000	8.54	35474 35456	SCVIR ACC	Joint SCVIR/ACC recommendation accepted See Attachment 8
23s	35484•	Transluminal peripheral atherectomy, open; brachiocephalic	000	11.01	35475 35458	SCVIR ACC	Joint SCVIR/ACC recommendation accepted See Attachment 8
23t	35485•	Transluminal peripheral atherectomy, open; tibioperoneal trunk	000	10.01	35470 35459	SCVIR ACC	Joint SCVIR/ACC recommendation accepted See Attachment 8
23u	35490•	Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery	000	11.59	35470 35471 35472 35473 35474 35475	SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
23v	35491•	Transluminal peripheral atherectomy, percutaneous; aortic	000	8.00		SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9
23w	35492•	Transluminal peripheral atherectomy, percutaneous; iliac	000	6.68		SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9
23x	35493•	Transluminal peripheral atherectomy, percutaneous; femoral-popliteal	000	8.54		SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9
23y	35494•	Transluminal peripheral atherectomy, percutaneous; brachlocephalic	000	11.00		SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9
23z	35495•	Transluminal peripheral atherectomy, percutaneous; tibioperoneal trunk and branches	000	10.01		SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9
161	36005•	Injection procedure for contrast venography (including introduction of needle or intracatheter)	XXX	1.80		SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9
163	37205•	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; initial vessel	000	12.53		SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
164	37206•	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; each additional vessel	000	6.26		SCVIR ACC ACR	Revised SCVIR recommendation accepted See Attachment 10
165	37207•	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; initial vessel	000	12.53		SCVIR ACC ACR	Joint SCVIR/ACC/ACR accepted See Attachment 9
166	37208•	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; each additional vessel	000	6.26		SCVIR ACC ACR	Revised SCVIR recommendation accepted See Attachment 10
167	438XX•	Gastroplasty, vertical-banded, for morbid obesity	090				No recommendation at this time
168	438XX•	Gastroplasty, other than vertical-banded, for morbid obesity	090				No recommendation at this time
171	47505•	Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)	000	2.00	50394 20501 75848 47500 74305	SCVIR ACR	Recommendation reflects RUC evaluation of SCVIR and ACR recommendations See Attachments 8 and 9
278	49315•	Laparoscopy, surgical; appendectomy	090	6.39	44950	ACS	Interim -- ACS recommendation to equate with open appendectomy (44950) accepted

Tracking Number	Code (● new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
172	49427●	Injection procedure (ie, contrast media) for evaluation of previously placed peritoneal-venous shunt (For radiological supervision and interpretation, see 75809)	010	1.90		SCVIR ACR	Recommendation reflects RUC evaluation of SCVIR and ACR recommendations See Attachment 9
6	49905●	Omental flap (eg, for reconstruction of sternal and chest wall defects) (list separately in addition to code for primary procedure)	ZZZ	9.19		STS	STS recommendation accepted See Attachment 7
174	50727●	Revision of urinary cutaneous anastomosis (any type urostomy);	090	11.73	44346	AUA	AUA recommendation accepted See Attachment 11
173	50728●	Revision of urinary cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia	090	10.30	44314	AUA	AUA recommendation accepted See Attachment 11
175	50780	Ureteroneocystostomy; anastomosis of single ureter to bladder ~~, or other operations for correction of vesicoureteral reflux~~	090	no change		AUA	CPT revision did not alter work of service
176	50782●	Ureteroneocystostomy; anastomosis of duplicated ureter to bladder	090	19.20	50785	AUA	AUA recommendation accepted See Attachment 11
177	50783●	Ureteroneocystostomy; anastomosis of single ureter to bladder ~~, or other operations for correction of vesicoureteral reflux~~; with extensive ureteral tailoring	090	20.20	50785	AUA	AUA recommendation accepted See Attachment 11

Tracking Number	Code (● new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
178	50785	Ureteroneocystostomy; anastomosis of single ureter to bladder ~~, or other operations for correction of vesicoureteral reflux~~; with vesico-Psoas hitch or bladder flap	090	no change		AUA	CPT revision did not alter work of service
180	52335	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method);	000	no change		AUA	CPT revision did not alter work of service
181	52339●	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method); with resection of tumor	000	9.30	52338 43264	AUA	AUA recommendation accepted See Attachment 11
182	56309●	Laparascopy, surgical; with removal of leiomyomata, subserosal (single or multiple)	090	5.89		ACOG	ACOG recommendation accepted See Attachment 2b
185	56405●	Incision and drainage of vulva or perineal abscess	010	1.48	56400 56000	ACOG AAFP	Joint ACOG/AAFP recommendation accepted
186	56605●	Biopsy of vulva or perineum (separate procedure); one lesion	000	.88	56000 56100	ACOG AAFP	Joint ACOG/AAFP recommendation accepted
187	56606●	Biopsy of vulva or perineum (separate procedure); each separate additional lesion	000	.44	56600 ACOG 11101 AAFP	ACOG AAFP	Joint ACOG/AAFP recommendation accepted
191	56631●	Vulvectomy, radical, partial; with unilateral inguinofemoral lymphadenectomy	090	16.00	56635 56630	ACOG	ACOG recommendation accepted See Attachment 2c

Tracking Number	Code (● new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
192	56632●	Vulvectomy, radical, complete;	090	14.00	56630 56635	ACOG	ACOG recommendation accepted See Attachment 2d
193	56633●	Vulvectomy, radical, complete; with unilateral inguinofemoral lymphadenectomy	090	17.50	56635 56640	ACOG	Reflects RUC evaluation of ACOG recommendation See Attachment 2e
194	56634●	Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy	090	18.45	56640	ACOG	Reflects RUC evaluation of ACOG recommendation
197	57415●	Removal of impacted vaginal foreign body (separate procedure) under anesthesia	010	.96	57410	ACOG	ACOG recommendation accepted See Attachment 2f
200	57460●	Colposcopy (vaginoscopy); (separate procedure) with loop electrosurgical excision(s) of the cervix (LEEP)	000	2.98	57454 57520	ACOG	ACOG recommendation accepted See Attachment 2g
207	58260	Vaginal hysterectomy; ~~with or without removal of tube(s), with or without removal of ovary(s)~~	090	no change		ACOG	CPT revision did not alter work of service
208	58262●	Vaginal hysterectomy; with removal of tube(s), and/or ovary(s)	090	14.50	58260	ACOG	ACOG recommendation accepted See Attachment 2h
205	582XX●	Vaginal hysterectomy; with removal of tube(s), and/or ovary(s), with repair of enterocele	090	16.00	58270 57268	ACOG	ACOG recommendation accepted See Attachment 2i

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
9	58345•	Transcervical introduction of fallopian tube catheter for diagnosis and/or reestablishing patency (any method), with or without hysterosalpingography (for insertion/removal of implantable contraceptive capsules, see 11975, 11976)	010	4.85		ACOG SCVIR ACR	ACOG/SCVIR/ACR consensus recommendation accepted See Attachment 12
209	58989•	Laparoscopy, surgical; with fulguration of oviducts (with or without transection); with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	010	14.61	58260 58988 58980 58985	ACOG	ACOG recommendation accepted See Attachment 2j
211	58991•	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	000	3.00	58990 58992	ACOG	ACOG recommendation accepted See Attachment 2k
212	58992	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C; with lysis of intrauterine adhesions ~~or resection of intrauterine septum~~ (any method)	000	3.30	58992	ACOG	Reflects RUC evaluation of ACOG recommendation See Attachment 2l
213	58993•	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C; with division or resection of intrauterine septum (any method)	000	3.70	58992	ACOG	Reflects RUC evaluation of ACOG recommendation See Attachment 2m
214	58994	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C; with removal of ~~submucous~~ leiomyomata	000	no change		ACOG	CPT revision did not alter work of service
215	58998•	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C; with removal of impacted foreign body	000	3.25	58990 58992	ACOG	ACOG recommendation accepted See Attachment 2n

Tracking Number	Code (● new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
218	61531●	Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring	090	19.26		AAN	Reflects RUC evaluation of AAN recommendation See Attachment 13
219	61532●	Stereotaxic implantation of depth electrodes into the cerebrum for long term seizure monitoring	090	22.88		AAN	Reflects RUC evaluation of AAN recommendation See Attachment 13
220	61533	~~Craniotomy, trephination, bone flap~~ Craniotomy with elevation of bone flap for subdural implantation of an ~~for insertion of epidural or subdural~~ electrode array for long term seizure monitoring	090	no change		AAN	CPT revision did not alter work of service
10	65860●	Severing adhesions of anterior segment, laser technique (separate procedure)	090	3.55	67031	AAO	AAO recommendation accepted See Attachment 5b
11	66825●	Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)	090	8.15	65235 66895	AAO	AAO recommendation accepted; reflects second survey See Attachment 5a
227	68761●	Closure of the lacrimal punctum; by plug, each	010	1.38	68760 68800	AAO	AAO recommendation accepted See Attachment 2b
12	74742●	Transcervical catheterization of fallopian tube, radiological supervision and interpretation	XXX	.65	74485 74365	SCVIR ACR	Reflects RUC evaluation of SCVIR and ACR recommendations

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
228	75809•	Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt) radiological supervision and interpretation (For procedure, see 49427 and 61070)	XXX	.50		SCVIR ACR	Recommendation reflects RUC evaluation of SCVIR and ACR recommendations
229	75960•	Transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel	XXX	1.24		SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 9
23aa-ee	75962 75964 75966 75968 75978	Transluminal balloon angioplasty, radiological supervision and interpretation	XXX	no change		SCVIR ACC	CPT revision did not alter work of service
23ff	75992•	Transluminal atherectomy, peripheral artery, radiological supervision and interpretation	000	.58	75962	SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 8
23gg	75993•	Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation	000	.37	75968	SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 8
23hh	75994•	Transluminal atherectomy, renal, radiological supervision and interpretation	000	1.38	75966	SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 8

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
23ii	75995•	Transluminal atherectomy, visceral, radiological supervision and interpretation	000	1.38	75966	SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 8
23jj	75996•	Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation	000	.37	75968	SCVIR ACC ACR	Joint SCVIR/ACC/ACR recommendation accepted See Attachment 8
230	76096	Preoperative placement of needle localization wire, breast, radiological supervision and interpretation ~~Localization of breast nodule or calcification before operation, with marker and confirmation of its position with appropriate imaging (eg, radiologic or ultrasound)~~	XXX	.60		SCVIR ACR	Recommendation reflects RUC evaluation of SCVIR and ACR recommendations
233	76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D) with or without M-mode recording;	XXX	no change		ACOG ACC ACR	CPT revision did not alter work of service
234	76826•	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D) with or without M-mode recording; follow-up or repeat study	XXX	.80	76825	ACOG ACC ACR	Recommendation reflects RUC evaluation of ACOG, ACC, and ACR recommendations Work is the same as 76825
232	76827•	Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; complete	XXX	.50	76825	ACOG ACC ACR	Joint ACOG/ACC/ACR recommendation accepted
232a	76828•	Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study	XXX	.50	76827	ACOG ACC ACR	Recommendation reflects RUC evaluation of ACOG, ACC, and ACR recommendations Work is the same as 76827

Tracking Number	Code (● new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
656	88156●	Cytopathology, smears, cervical or vaginal, (TBS) up to three smears; requiring interpretation by physician	XXX	.44	88151	CAP ASC ASCP	Joint CAP/ASC/ASCP recommendation that work be set equal to 88151 accepted
23kk-ll	92982 92984	Percutaneous transluminal coronary balloon angioplasty	000	no change		SCVIR ACC	CPT revision did not alter work of service
23mm	92995●	Percutaneous transluminal coronary atherectomy, any method, with or without balloon angioplasty; single vessel	000	16.25		ACC ACR	Recommendation reflects RUC evaluation of ACC and ACR recommendations See Attachments 9 and 14
23nn	92996●	Percutaneous transluminal coronary atherectomy, any method, with or without balloon angioplasty; single vessel; each additional vessel	000	6.00		ACC ACR	Recommendation reflects RUC evaluation of ACC and ACR recommendations See Attachments 9 and 14
13	93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, and/or pharmacologial stress, with physician supervision, with interpretaton and report (For echocardiography, see 93307-93350)	XXX	no change		ACC	CPT revision did not alter work of service
240	93312	Echocardiography, real time with image documentation (2-D) (with or without M-mode recording), transesophageal; including probe placement, image acquisition, interpretation and report	XXX	no change		ACC ACR	CPT revision did not alter work of service -- appears undervalued

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
239	93313•	Echocardiography, real time with image documentation (2D) (with or without M-Mode recording), transesophageal; placement of transesophageal probe only	XXX	.6 x 93312	93312	ACC ACR	Reflects RUC evaluation of joint ACC/ACR recommendation
241	93314•	Echocardiography, real time with image documentation (2D) (with or without M-Mode recording), transesophageal; image acquisition, interpretation and report only	XXX	.6 x 93312	93312	ACC ACR	Reflects RUC evaluation of joint ACC/ACR recommendation
242	93980•	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	XXX	2.30	54240	AUA ACR	Joint AUA/ACR recommendation accepted See Attachment 11
243	93981•	Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study	XXX			AUA ACR	No recommendation at this time -- current use of code unclear, AUA feels that work value should be the same as 93980 if used
14	95010•	Sequential and incremental tests with appropriate allergens, percutaneous tests (scratch, puncture, prick) with drugs, biologicals or venoms, specify number of tests	XXX	.15		JCAI AAO-HNS	Recommendation based on RUC evaluation of joint JCAI/AAO-HNS recommendation
15	95015•	Sequential and incremental tests with appropriate allergens, intracutaneous (intradermal) tests, with drugs, biologics, or venoms, immediate reaction 15 to 20 minutes, specify number of tests	XXX	.15		JCAI AAO-HNS	Recommendation based on RUC evaluation of joint JCAI/AAO-HNS recommendation

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
16	95075	Ingestion challenge test (sequential and incremental ingestion of test items eg, food, drug or other substance such as metabisulfite)	XXX	2.00		JCAI AAO-HNS	Recommendation based on RUC evaluation of joint JCAI/AAO-HNS recommendation
262	95883•	Neuropsychological testing with report, per hour (eg, LURIA, Halstead battery, WAIS)	XXX			AAN	No recommendation at this time – usually not a physician service
263	95950	Monitoring for ~~localization~~ identification and lateralization of cerebral seizure focus by attached electrodes ~~or radiotelemetry~~; electroencephalographic (8 channel EEG) recording and interpretation, each ~~initial~~ 24 hours	XXX	no change		AAN	CPT revision did not alter work of service
264	95951	Monitoring for ~~localization~~ identification and lateralization of cerebral seizure focus by attached electrodes ~~or radiotelemetry~~; combined electroencephalographic (EEG) and video recording and interpretation, each ~~initial~~ 24 hours	XXX	4.25	99255	AAN	AAN recommendation accepted See Attachment 15
266	95953•	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG; electroencephalographic (EEG) recording and interpretation, each 24 hours	XXX	3.44	99255 95951	AAN	AAN recommendation accepted See Attachment 15
267	95956•	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry; electroencephalographic (EEG) recording and interpretation, each 24 hours	XXX	3.44	99255 95951	AAN	AAN recommendation accepted See Attachment 15
18	96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	000	2.50		ASCO	ASCO recommendation accepted See Attachment 16

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
19	96445	Chemotherapy administration into peritoneal cavity, requiring and including ~~paracentesis~~ abdominocentesis	000	2.31		ASCO	ASCO recommendation accepted See Attachment 16
20	96450	Chemotherapy administration into CNS (eg, intrathecal), requiring and including lumbar puncture	000	2.00		ASCO AAN	ASCO and AAN consensus on ASCO recommendation accepted See Attachment 16
268	97545•	Work hardening/conditioning; initial 2 hours	XXX			AAPMR	No recommendation at this time -- usually not a physician service
269	97546•	Work hardening/conditioning; each additional hour	XXX			AAPMR	No recommendation at this time -- usually not a physician service
273	99291	Critical care, ~~including the diagnostic and therapeutic services and direction of care of the critically ill or multiply injured or comatose patient,~~ evaluation and management of the critically ill or critically injured patient, requiring the ~~prolonged presence~~ constant attendance of the physician; first hour	XXX	4.00		SCCM	Interim -- reflects RUC evaluation of SCCM comments to HCFA See Attachment 17
274	99292	Critical care, ~~including the diagnostic and therapeutic services and direction of care of the critically ill or multiply injured or comatose patient,~~ evaluation and management of the critically ill or critically injured patient, requiring the ~~prolonged presence~~ constant attendance of the physician; each additional 30 minutes	XXX	2.00		SCCM	Interim -- reflects RUC evaluation of SCCM comments to HCFA See Attachment 17
270	99295•	Initial NICU care, per day, for the evaluation and management of a critically ill neonate or infant	XXX				No recommendation at this time -- will review for next cycle

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
271	99296•	Subsequent NICU care, per day, for the evaluation and management of a critically ill and unstable neonate or infant	XXX				No recommendation at this time -- will review for next cycle
272	99297•	Subsequent NICU care, per day, for the evaluation and management of a critically ill and stable neonate or infant	XXX				No recommendation at this time -- will review for next cycle
275	99XX1•	Initial observation care, per day, with the evaluation and management of a patient which requires these three key components: o a detailed or comprehensive history; o a detailed or comprehensive examination; and o medical decision making that is straight forward or of low complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the problem(s) requiring admission to "observation status" are of low severity.	XXX	1.13	99221	AAFP	Interim -- reflects RUC evaluation of AAFP recommendation to equate with corresponding initial hospital visit code

Tracking Number	Code (• new)	Descriptor	Global Period	Recommended Physician Work RVUs	Key Reference Service(s)	Specialty Society(s)†	Comments
276	99XX2•	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: o a comprehensive history; o a comprehensive examination; and o medical decision making of moderate complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the problem(s) requiring admission to "observation status" are of moderate severity.	XXX	1.84	99222	AAFP	Interim – reflects RUC evaluation of AAFP recommendation to equate with corresponding initial hospital visit code
277	99XX3•	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: o a comprehensive history; o a comprehensive examination; and o medical decision making of high complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the problem(s) requiring admission to "observation status" are of high severity.	XXX	2.54	99223	AAFP	Interim – Reflects RUC evaluation of AAFP recommendation to equate with corresponding initial hospital visit code

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July 7, 1992

William Toby, Jr.
Acting Administrator
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Dear Mr. Toby:

It is my pleasure to submit the following recommendations of the AMA/Specialty Society RVS Update Committee (RUC). These recommendations, presented in Table 1, address relative physician work values for the Medicare RBRVS for 253 new or revised codes to be included in the 1993 edition of Physicians' Current Procedural Terminology (CPT). They reflect decisions made at the May 30-31 and June 25-28 meetings of the RUC. The vast majority of these codes originated at the May 8-10 CPT Editorial Panel Meeting and were addressed by the RUC in June. I believe that this timetable demonstrates the RUC's ability to respond quickly to all coding developments.

The RUC was formed in November of 1991 and grew out of a series of discussions with major national medical specialty societies. Prior to and after the formation of the RUC, AMA staff have met with senior HCFA staff to assist us in designing an RVS update process that would best meet HCFA's needs.

The RUC is comprised of 26 members. Twenty two are representatives of major specialty societies. The remaining members represent the American Medical Association, the American Osteopathic Association, and the CPT Editorial Panel. I was appointed Chairman of the RUC by the AMA. Appendix 1 lists the current members of the RUC and their affiliations.

The work of the RUC is supported by an Advisory Committee (AC) made up of representatives of all 85 specialty societies in the AMA House of Delegates. Each AC member is asked to designate a specialty society RVS Committee. These committees generate the recommendations presented to the RUC by each relevant AC member.

The RUC operates under formal documents outlining its Structure and Functions and Rules and Procedures. These are attached as Appendix 2. In addition, the RUC adopted a methodology for the first year of its work. This methodology, together with its organizing documents, is designed to produce relative work values that are consistent with the

current Medicare RBRVS, can be integrated into HCFA's RBRVS refinement efforts, reflect standard protocols across specialty societies, and have high face validity. The best description of the current method can be found in a sample of the survey instrument provided to participating specialty societies. This is Appendix 3.

The following brief review of the RUC process and method will be helpful as you consider our recommendations.

1. The CPT Editorial Panel adds new codes or revises current codes at one of its meetings. This information is transmitted to the RUC.

2. The RUC staff, in close cooperation with CPT staff, summarize Editorial Panel actions and transmit this information to the AC. AC members indicate their level of interest in each code (i.e., develop a formal recommendation, comment on recommendations, no interest, or coding change should not change physician work).

3. RUC staff work with AC members and their specialty society to develop a customized survey instrument for use in a magnitude estimation of codes of interest. This instrument uses reference services identified by the AC member and provides the full descriptor of each code under study. (See Appendix 3.)

4. The AC member works with his specialty society's RVS Committee to administer the survey. In general, the survey is first completed by mail by the society's RVS Committee, which then meets to review the median values for each code, and adjusts these results as warranted by a detailed clinical discussion of the results. This small group survey method reflects Phase III of the Hsiao study.

5. The AC member forwards the specialty's recommendations to the RUC. Multiple societies and specialties developing recommendations for the same code are encouraged to collaborate early in this process.

6. AC recommendations are sent to RUC members and commenting AC members prior to the meeting of the RUC. These recommendations document the methods used in developing the recommendation, summarize survey data, and indicate key reference services.

7. The RUC considers specialty recommendations and comments in an open meeting. It votes on each recommendation, with a 2/3 vote required for acceptance. If it does not accept a recommendation, it refers it to the originating AC member and to a facilitation committee, which returns with a recommendation for consideration.

In the case of multiple recommendations, the RUC may either accept one of the recommendations or refer them to a facilitation committee for resolution. In most instances, specialties agreed on a consensus recommendation to the RUC.

Through this method, the RUC was able to dispose of all items of business that it has considered. As indicated in Table 1, the RUC took the following actions:

- No recommendation made, code revision will not alter work.
- Revised code surveyed, code revision will not alter work.
- Recommended change in value for revised code.
- Recommended value for new code.
- Interim recommended value, full RUC review for next cycle.
- Recommendation in the form of a ratio to a current code.
- No recommendation at this time given available data.

I would like to underscore several points about the RUC process.

- The RUC accepts the Medicare RBRVS as its framework, while recognizing that the RBRVS is undergoing refinement.

- The process adapts both the Harvard RBRVS and HCFA refinement methods to the needs and requirements of RVS updating.

- The RUC, like HCFA, uses reference services to value services. For the RUC, reference services are specialty specific and serve as a ruler against which to evaluate each new or revised code. Thus, although a key reference service used to value a code may have a similar value, it often does not.

- The RUC process is extremely open. The RUC itself provides broad representation of the medical profession. The AC includes many more specialties and societies.

- The RUC is committed to due process. Due to the severe time constraints this year, it attempted to resolve all disagreements at the June meeting through the use of facilitation committees at that same meeting. Although this approach was quite successful, in the future, the RUC intends to implement a more formal reconsideration process.

- The key to the methodology is review during RUC meetings. RUC members subject each recommendation to exacting scrutiny. Methods and clinical comparisons undergo rigorous review and AC members must defend every aspect of their recommendations. The RUC does not hesitate to refer a recommendation back to the specialty or to a facilitation committee.

The RUC's recommendations are summarized in Table 1. This table contains each new or revised CPT code for which the RUC is making a recommendation. A large number of revised codes not listed have been identified by AC members as not requiring a reevaluation of physician work. In addition, as evidenced by a number of our recommendations, the RUC adopted as a general principle that minor wording changes to an existing code should not be the occasion for change in the relative work value for that code. Table 1 contains the following information:

Column 1: Internal RUC tracking number. (Omitted numbers were assigned to codes not requiring a recommendation.)

Column 2: CPT code. (Code numbers are subject to minor revisions prior to finalization of CPT 1993.)

Column 3: Descriptor for new or revised code. (Descriptors subject to minor revision prior to finalization of CPT 1993.).

Column 4: Global period. (Based on information supplied by HCFA).

Column 5: Recommended relative work value. (Where no recommendation is indicated, see Column 8 for reasons (i.e., "no change in work" for revised code or "no recommendation at this time" for new codes). Also, several recommendations are expressed as ratios to existing codes to reflect HCFA's refinement process and specialty concerns with existing values.

Column 6: Key reference service. (As indicated by recommending AC member(s) and/or RUC review. Note that the RUC does not focus on equivalence to reference services.)

Column 7: Specialty Societies making recommendation(s).

Column 8: Comments. (These include the basis for the RUC recommendation as well as any special considerations. Where relevant, it also indicates, by Attachment number, specialty documentation supporting the RUC recommendation.)

Mr. Toby, I am confident that the Health Care Financing Administration will find these recommendations extremely useful as it prepares its regulations for the 1993 Medicare Fee Schedule. We have been informed by HCFA staff that our submission will be timely for planned HCFA review activities. We have expended considerable resources to complete and submit these recommendations on this schedule.

Based on what all involved consider an extraordinarily successful first year, the RUC is proceeding with plans to develop recommendations for new or revised codes for CPT 1994. In preparation for these efforts, the RUC will proceed with refinements to its process and methods, and will explore ways in which it can assist HCFA with the ongoing maintenance of the RBRVS. It will also implement a Health Care Professionals Advisory Committee to include all relevant non-MD/DO health professions. We would be pleased to consult with HCFA on the composition of this committee. Finally, I would welcome the opportunity to consult with you and your staff on any other ways in which our efforts can best complement yours.

If you have questions about any element of this submission, please contact Dorothy J. Moss (202-789--7411) of the AMA.

Sincerely,

Grant

Grant V. Rodkey, MD

GVR/mjs

cc: James S. Todd, MD

Attachments

American Medical Association
Physicians dedicated to the health of America

James S. Todd, MD
Executive Vice President

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

July 7, 1992

Louis W. Sullivan, MD
Secretary of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Dear Doctor Sullivan:

It is my pleasure to provide you with a copy of the first annual recommendations of the AMA/Specialty Society RVS Update Committee (RUC). These recommendations were transmitted by the Chairman of the RUC, Grant V. Rodkey, MD to Mr. William Toby, Jr. on July 6. They address relative work values for the new Medicare RBRVS for 253 new or revised codes to be included in the 1993 edition of Physicians' Current Procedural Terminology (CPT). These recommendations reflect decisions at the May 30-31 and June 25-28 meetings of the RUC and are summarized in Table 1 of Doctor Rodkey's letter to Mr. Toby.

The RUC was formed in November of 1991 and grew out of a series of discussions with major national medical specialty societies. Prior to and after the formation of the RUC, AMA staff have met with senior HCFA staff to assist us in designing an RVS update process that would best meet HCFA's needs.

The RUC has 26 members. Twenty two are representatives of major specialty societies. The remaining members represent the American Medical Association, the American Osteopathic Association, and the CPT Editorial Panel. Grant V. Rodkey, MD has been appointed Chairman.

The RUC's work is supported by an Advisory Committee (AC) made up of all 85 specialty societies in the AMA House of Delegates. Each AC member is asked to designate a specialty society RVS Committee. These committees generate recommendations sent to the RUC by each relevant AC member.

The RUC operates under formal documents outlining its Structure and Functions and Rules and Procedures. In addition, it has adopted a methodology designed to produce relative work values that are consistent with the current Medicare RBRVS, can be integrated into HCFA's RBRVS refinement efforts, reflect standard protocols across specialty societies, and have high face validity.

The RUC process can be summarized as follows. First, the CPT Editorial Panel adds new codes or revises current codes. Second, this information

is transmitted to the RUC, which forwards a summary to all AC members, who indicate their level of interest in each code. Third, AMA staff work with AC members to develop a survey instrument for use with each code of interest. Fourth, AC members work with their specialty society RVS Committees to administer the survey. Fifth, the AC members forward recommendations to the RUC. (Coordination among AC members at this stage is strongly encouraged. Joint proposals among AC members who have chosen to survey is desired, although not requisite.) Sixth, AC recommendations are sent to RUC members and interested AC members prior to the meeting of the RUC. Seventh, the RUC considers specialty recommendations and comments in an open meeting. A 2/3 vote is required for acceptance. A facilitation committee process is available for recommendations not accepted as presented. Through this method, the RUC disposed of all items of business before it.

I would like to underscore several points about the RUC process. The RUC accepts the Medicare RBRVS as its framework, while recognizing that the RBRVS is undergoing refinement. Thus, it has adapted both the Harvard RBRVS and HCFA refinement methods to the needs and requirements of RVS updating. In addition, its process is extremely open and committed to due process. Finally, the key to the RUC methodology is exacting clinical and methodological review by RUC members during their meetings.

Mr. Secretary, I am confident that HCFA will find these recommendations extremely useful as it prepares its regulations for the 1993 Medicare Fee Schedule. We have been informed by HCFA staff that our submission will be timely. As you can imagine, we have expended considerable resources to complete and submit these recommendations on this schedule. Indeed, the vast majority of these codes originated at the May 8-10 CPT Editorial Panel Meeting and were addressed by the RUC in June.

Based on an extraordinarily successful first year, the RUC is proceeding with plans to develop recommendations for 1994. It is refining its process and methods, and will explore ways in which it can assist HCFA with the ongoing maintenance of the RBRVS. It will also implement a Health Care Professionals Advisory Committee to include all relevant non-MD/DO health professions. We intend to work closely with HCFA staff in an effort to best complement their activities. I will continue to keep you abreast of our progress and look forward to your input into this important project.

In closing, I want to underscore that the American Medical Association is fully committed to devote the resources necessary to make the RUC process a continuing success. We view this new endeavor as a milestone in our relationship with both the federal government and the national medical specialty societies.

Sincerely,

James S. Todd, MD

JST/mjs

cc: Grant V. Rodkey, MD

Attachments

Glossary of Specialty Society Acronyms

American Academy of Dermatology (AAD)
American Academy of Family Physicians (AAFP)
American Academy of Neurology (AAN)
American Academy of Ophthalmology (AAO)
American Academy of Orthopaedic Surgeons (AAOS)
American Academy of Otolarygology - Head and Neck Surgery (AAO-HNS)
American Academy of Plastic and Reconstructive Surgeons, Inc. (AAPRS)
American College of Cardiology (ACC)
American College of Obstetricians and Gynecologists (ACOG)
American College of Radiology (ACR)
American College of Surgeons (ACS)
American Society of Anesthesiologists (ASA)
American Society of Clinical Pathologists (ASCP)
American Society of Cytology (ASC)
American Thoracic Society (ATS)
American Urological Association (AUA)
College of American Pathologists (CAP)
Joint Council of Allergy and Immunology (JCAI)
Society of Cardiovascular and Interventional Radiology (SCVIR)
Society of Critical Care Medicine (SCCM)
Society of Thoracic Surgeons (STS)

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Grant V. Rodkey, MD
Chairman
AMA/Specialty Society RVS
Update Committee

515 North State Street
Chicago, Illinois 60610

312 464-4726
312 464-5849 Fax

Memo to: William R. Felts, MD
T. Reginald Harris, MD

From: Grant V. Rodkey, MD Grant

Date: July 10, 1992

Subject: Recommendations Submitted to HCFA

It is with a great deal of pleasure that I enclose for your information a copy of the first annual recommendations of the AMA/Specialty Society RVS Updating Committee (RUC) for physician work relative values for new and revised CPT codes. These recommendations were submitted to the Acting HCFA Administrator, Mr. William Toby, Jr., on July 6. Doctor Todd also forwarded a copy of the recommendations to Louis W. Sullivan, MD, Secretary of HHS. Attached are copies of these letters, along with a table listing the recommendations for new codes to be included in CPT 1993 and for any revised codes surveyed by the RUC Advisory Committee.

We are, of course, very proud of these recommendations. Despite an extremely compressed timetable for this cycle, we were able to develop and approve recommendations for 253 codes to be included in CPT 1993. In so doing, I believe that we demonstrated to both the medical profession and the government that the AMA/Specialty Society RVS Update Process can effectively represent the profession in maintaining and updating the Medicare RBRVS. If you have any questions about the RUC process or these recommendations, please contact Sandy Sherman at the AMA (312-464-4455). Ms. Sherman will also be available at your July 31 meeting to assist Doctor Gordy in answering any questions you or the members of the CPT Editorial Panel may have about the RUC.

Doctor Gordy's participation on the RUC has been invaluable to our process. Clearly, the RUC could not have fulfilled its task without the cooperation of and assistance provided by Doctor Gordy, the Editorial Panel and its staff, and I want to take this opportunity to thank you and your staff on behalf of the entire RUC. The Forum at the House of Delegates Annual Meeting illustrated the importance of maintaining a close relationship between the CPT editorial process and the RVS updating process, and I look forward to working with you to strengthen that relationship in the coming year.

Attachments

cc: Tracy R. Gordy, MD
Barry S. Eisenberg
Sandra L. Sherman
Celeste G. Kirschner
Mark J. Segal, PhD

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News Release

FOR IMMEDIATE RELEASE

For further information contact: Lisa Levin, 312/464-2410

AMA/SPECIALTY SOCIETIES SUBMIT RBRVS RECOMMENDATIONS TO HCFA

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"These recommendations represent the commitment of the medical community to work with HCFA in its continuing efforts to improve the Medicare payment system," said RUC Chairman Grant V. Rodkey, M.D.

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According to Rodkey, the RUC subjects all recommendations to exacting scrutiny. Methods and clinical comparisons undergo comprehensive review and members of the advisory committee must defend every aspect of their recommendation.

The RUC recommendations are intended to assist HCFA as it prepares regulations for the 1993 Medicare Fee Schedule.

Based on the success of its first year, the RUC is proceeding with plans to develop recommendations for 1994. It is also refining its process and methods, exploring ways to assist HCFA with ongoing RBRVS maintenance and implementing a Health Care Professionals Advisory Committee to include all relevant non-MD/DO health professionals who use CPT for reimbursement under Medicare.

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Department of Payment Update

Date: July 14, 1992

From: Sandy Sherman SS

To: Kathy Kuntzman

Subject: RUC Recommendations

For your information . . .

Department of Payment Update

Date: July 14, 1992

From: Sandy Sherman SS

To: Dorothy Moss

Subject: RUC Recommendations

Here is a copy of the letters to Sullivan and Toby and final table of recommendations for your information and/or file (in case you're looking for something to read one day).

Department of Payment Update

Date: July 14, 1992

From: Sandy Sherman SS

To: Bruce Blehart

Subject: RUC Recommendations

Attached for your information and files are copies of the letters to Doctor Sullivan and Mr. Toby conveying the RUC recommendations for 1992.

Department of Payment Update

Date: July 14, 1992

From: Sandy Sherman SS

To: Ross Rubin

Subject: RUC Recommendations

Attached for your information and files are copies of the letters to Doctor Sullivan and Mr. Toby conveying the RUC recommendations for 1992.

Department of Payment Update

Date: July 14, 1992

From: Sandy Sherman SS

To: Kurt Gillis

Subject: RUC Recommendations

Attached for your information and files is a copy of the RUC recommendations for 1992. Thanks for all your help -- I hope you will be able to attend a portion of the November meeting.

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"These recommendations represent the commitment of the medical community to work with HCFA in its continuing efforts to improve the Medicare payment system," said RUC Chairman Grant V. Rodkey, M.D.

The 26-member RUC consists of representatives from 22 major specialty societies, the AMA, the American Osteopathic Association and the CPT Editorial Panel. It is supported by an advisory committee composed of representatives from all 85 specialty societies in the AMA. Each member of this committee designates a specialty society RVS committee from which recommendations are generated.

The RUC operates under formal methods and rules designed to produce relative work values consistent with the current Medicare RBRVS. According to Rodkey, these values can be integrated into HCFA's RBRVS refinement efforts and reflect standard protocols among specialty societies.

-more-

515 North State Street
Chicago, Illinois 60610
312 464 4430

The RUC made recommendations for a total of 253 codes. The recommendations only concern new codes and revised codes which require a reevaluation of a physician's work for a given procedures. No recommendations were made for code revision that did not alter physician work.

According to Rodkey, the RUC subjects all recommendations to exacting scrutiny. Methods and clinical comparisons undergo comprehensive review and members of the advisory committee must defend every aspect of their recommendation.

The RUC recommendations are intended to assist HCFA as it prepares regulations for the 1993 Medicare Fee Schedule.

Based on the success of its first year, the RUC is proceeding with plans to develop recommendations for 1994. It is also refining its process and methods, exploring ways to assist HCFA with ongoing RBRVS maintenance and implementing a Health Care Professionals Advisory Committee to include all relevant non-MD/DO health professionals who use CPT for reimbursement under Medicare.

"The American Medical Association views this endeavor as a milestone in our relationship with both the federal government and the national medical specialty societies," said James S. Todd, M.D., AMA executive vice president. "We are fully committed to devote the resources necessary to make this process work."

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American Medical Association
Physicians dedicated to the health of America

News Release

FOR IMMEDIATE RELEASE

For further information contact: Lisa Levin, 312/464-2410

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APPENDICES

APPENDIX 1

AMA/Specialty Society RVS Update Process

RVS UPDATE COMMITTEE (RUC) MEMBERS

Grant V. Rodkey, MD	Chairman
Donald T. Lewers, MD	American Medical Association
Tracy Gordy, MD	American Medical Association CPT Editorial Panel
Robert K. Anzinger, MD, FACEP	American College of Emergency Physicians
Robert Berenson, MD	American College of Physicians
John O. Gage, MD	American College of Surgeons
Michael Graham, MD	American Academy of Orthopaedic Surgeons
W. Benson Harer, Jr., MD	American College of Obstetricians and Gynecologists
James G. Hoehn, MD	American Society of Plastic and Reconstructive Surgeons
Allan Jensen, MD	American Academy of Ophthalmology
George F. Kwass, MD	College of American Pathologists
Michael D. Maves, MD	American Academy of Otolaryngology - Head and Neck Surgery, Inc.
David L. McCaffree, MD	American Academy of Dermatology
Kenneth A. McKusick, MD	American College of Nuclear Physicians The Society of Nuclear Medicine
George E. Miller, Jr., MD	Society of Thoracic Surgeons
James M. Moorefield, MD	American College of Radiology
L. Charles Novak, MD	American Society of Anesthesiologists
Eugene S. Ogrod, II, MD	American Society of Internal Medicine
Bergein F. Overholt, MD	American College of Gastroenterology American Gastroenterology Association American Society for Gastrointestinal Endoscopy

Byron Pevehouse, MD	American Association of Neurological Surgeons
Chester W. Schmidt, Jr., MD	American Psychiatry Association
Gregory A. Slachta, MD	American Urological Association
Ray E. Stowers, DO	American Osteopathic Association
Richard Tuck, MD	American Academy of Pediatrics
John Tudor, Jr., MD	American Academy of Family Physicians
William L. Winters, Jr., MD	American College of Cardiology

June 1992

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APPENDIX 2

RULES AND PROCEDURES FOR THE AMERICAN MEDICAL ASSOCIATION/SPECIALTY SOCIETY RELATIVE VALUE UPDATE PROCESS ("RULES AND PROCEDURES") ("PROCESS")

I. Process for Relative Value Development

A. American Medical Association ("AMA") staff will receive periodically throughout the year Physicians' Current Procedural Terminology, Fourth Edition, Copyright American Medical Association ("CPT") CPT coding revisions (including new or revised codes) from AMA staff responsible for CPT Editorial revisions as soon as possible after CPT Editorial Panel minutes are approved. In addition, AMA staff responsible for RVS updating will maintain close liaison with those AMA staff responsible for CPT in order to facilitate planning and logistics for the RUC.

B. The RUC with the assistance of the AMA, will develop a mechanism for those individuals and entities proposing the CPT coding changes to the CPT Editorial Panel, to submit to the RUC preliminary basic materials that may be necessary later for relative value development.

For purposes of this Process, "relative values" shall mean a series of comparative weights derived from a variety of sources for the provision of services and procedures.

C. The RUC with the assistance of the AMA will develop and approve the relative value update agenda (i.e., the listing of new or revised codes or other services for which relative values must be established, as well as the timetable for accomplishing this work and for RUC consideration of RVS recommendations.) All representatives of the RUC will receive written notification of the update agenda prior to any meeting.

D. The RUC will utilize the Advisory Committee (AC) and Specialty Society Committees, as appropriate to develop relative value data for new or revised CPT codes. Each specialty society represented on the AC will be asked to designate a committee responsible for developing relative value recommendations using protocols developed by the Research Subcommittee and adopted by the RUC. Each Advisory Committee member will serve as the formal liaison between the respective Specialty Committee and the RUC. Where multiple societies exist for a particular specialty, these societies will be encouraged to designate a joint Specialty Committee. The RUC, AC and Specialty Society Committees will utilize standard research protocols, methodology and underlying documentation developed by the Research Subcommittee as adopted by the RUC to develop the relative value data. In the event that the services represented by new codes are provided in meaningful numbers by more than one specialty as determined by the RUC it will be necessary to consider the recommendations of each of the relevant specialties.

E. The RUC will obtain comments from the relevant Health Care Professional Advisory Committee (HCPAC) and the Third Party Advisory Committee (TPAC) (when they are constituted and operational) on all proposed relative values.

F. The RUC will consider the recommendation(s) of the AC, HCPAC, TPAC and Specialty Society Committee and will formulate annual recommendation(s) for Health Care Financing Administration (HCFA).

1. RUC will evaluate whether Specialty Society recommendations were developed with proper RUC protocols and requirements.

2. RUC will also ensure consideration of potential impacts on various specialties, subspecialties and practice types.

3. RUC will also consider additional available scientific and economic information in its deliberations.

4. The RUC will provide the opportunity for in-person presentations or at the discretion of the Chairman, submission of written comments by interested parties as follows:

   a. In-person presentations by members of the Advisory Committee making a recommendation at an RUC meeting will be invited in all cases.

   b. In-person presentations by members of the Advisory Committee who have expressed an interest in a recommendation being discussed at an RUC meeting will be allowed at the discretion of the Chairman.

   c. In-person presentations by other interested parties who have expressed an interest in a recommendation being discussed at an RUC meeting will be allowed at the discretion of the Chairman.

   d. Written comments by members of the Advisory Committee and other interested parties will be considered by the RUC and placed in its agenda materials if they are received timely.

G. The RUC will take one of four actions on all issues of assignment of relative values. All RUC actions on RVS recommendations will require a two thirds vote of those representatives present.

1. Accept the Specialty Society Committee recommendation and forward it to HCFA.

2. Accept a portion of the Specialty Society Committee recommendation, which may address multiple codes and refer the remaining portion back to the Specialty Society Committee for further consideration.

3. Refer the entire recommendation back to the appropriate Specialty Society Committee.

   In the event of a referral back to the Specialty Society Committee, the Chairman will appoint an ad hoc facilitation committee to expedite the resolution of any referred items to enable timely reconsideration and approval by the RUC.

   Members of the Ad Hoc Facilitation Committee will be appointed by the Chairman based on the following criteria:

   a. members will be representative of the appropriate spectrum of medical practice.

   b. members will not be direct parties to the dispute.

   c. members will be unbiased and objective

4. Coordinate the integration of recommendations from multiple Specialty Society Committees as necessary. (See 17D of "Methodology.")

H. All RUC actions as noted in 1-4 above shall include a detailed rationale.

I. The RUC prior to making any recommendations to HCFA will notify in writing all representatives of the appropriate Committees and Subcommittees of its proposed recommendation.

J. In the event that the RUC has not accepted Specialty Society recommendation(s) in the time frame(s) necessary to notify HCFA (in order for HCFA to comply with the annual cycle to assign relative values to new CPT codes), the RUC, at its option may forward to HCFA:

(1) all of the records concerning the outstanding recommendation(s) for HCFA's independent evaluation and assignment of relative values to new CPT codes, or

(2) forward a portion of the records concerning the outstanding recommendation(s) for HCFA's independent evaluation and assignment of relative values to new CPT codes, or

(3) the RUC may choose by a two thirds majority vote of those present to formulate and include with these materials its own assessment of the appropriate relative value, or

(4) the RUC may choose by a two thirds vote of those present to formulate and include with these materials its own assessment of the appropriate range in which the appropriate relative value lies.

STRUCTURE AND FUNCTIONS OF THE AMERICAN MEDICAL ASSOCIATION/ SPECIALTY SOCIETY RELATIVE VALUE UPDATE PROCESS ("STRUCTURE AND FUNCTIONS") ("PROCESS")

I. PURPOSE

The American Medical Association (AMA) has established a Process in the course of its activities to develop relative values (RVS) for new or revised Physicians' Current Procedural Terminology, 4th Edition, Copyright American Medical Association ("CPT") CPT codes. This Process was established in the course of the AMA's normal activities and as a basis for exercising its First Amendment right to petition the Federal Government as part of its research and data collection activities, for monitoring economic trends and in connection and related to the CPT development process.

In addition, Health Care Financing Administration (HCFA) is mandated to make appropriate adjustments to the new Medicare Resource Based Relative Value Scale (RBRVS) in response to the Omnibus Budget Reconciliation Act of 1989 to account for changes in medical practice coding and new data and procedures. The purpose of this Process, in addition to satisfying the purposes noted in this first paragraph of this section, will be to provide recommendations to HCFA for use in annual updates to the new Medicare RVS.

II. OBJECTIVE

A primary objective of this Process is that new relative work values will be available for use with new or revised CPT codes in the same year that CPT codes are introduced.

Relative value recommendations will initially focus on the physician work component of the Medicare RVS. In the future the Process may be used to establish the overhead and professional liability components of the RVS.

In addition, as deemed appropriate by the RUC, this process may be used to develop information on the physician work component for potential proposals for new codes to assist specialty societies in developing complete documentation for requests for new or revised codes where work information will be pertinent.

For purposes of this Process "relative values" shall mean a series of comparative weights derived from a variety of sources for the provision of services and procedures.

III. ORGANIZATION AND STRUCTURE

The Process will utilize an RVS Update Committee, three Advisory Committees and appropriate Subcommittees as further described below. The Process and all Committees and Subcommittees will be separate and distinct from the CPT Editorial Panel both in structure and process. The Process will coordinate with the CPT Editorial Panel as further described herein.

A. RVS Update Committee

(1) Purpose - The American Medical Association (AMA) will convene and chair the RVS Update Committee (RUC). The principal role and purpose of the RUC will be to provide final RVS update recommendations to HCFA.

(2) Composition - The RUC shall be composed of physician representatives from the twenty-two main medical specialties as indicated on Appendix 1 as attached hereto and made a part hereof. The AMA and the American Osteopathic Association (AOA) shall also each have one representative to the RUC. The AMA and the AOA shall also each have one alternate representative to the RUC to participate and vote at the RUC only in the absence of the respective AMA and AOA representative. The Chairperson shall also have one seat and shall be appointed by the AMA. A

member of the CPT Editorial Panel as selected by the AMA shall also be a non-voting representatives to RUC. The RUC shall include two rotating seats whose membership shall rotate every two years. Each term will conclude with the provision of final recommendations to HCFA for the following year's CPT codes. One seat will be reserved for an internal medicine subspecialty. The other will be open to any other specialty society not a member of the RUC. The specialties and associated specialty societies to fill these seats will be determined by the RUC in accordance with its normal decision-making processes.

(3) Designation of Specialty Society Representatives - Specialty society representatives shall be nominated by the respective Specialty Society. One alternate specialty society representative shall also be nominated by each of the Specialty Societies to participate and vote at the RUC only in the absence of the respective Specialty Society representative. Specialty Society representatives, to the extent practicable, shall not be members of the CPT Editorial Panel or CPT Advisory Committee or Advisory Committee as described herein. The AMA shall approve all Specialty Society nominations to the RUC.

(4) Terms of Appointment:

(a) Specialty Society and AOA Representatives and Alternate Representatives: shall hold terms of three (3) years, with a maximum tenure of six (6) years.

(b) Chairperson: The Chairperson of the RUC shall hold an annual term of two (2) year, with a maximum tenure of four (4) years.

(c) AMA: AMA representative and alternate representative shall hold terms of two (2) years, with a maximum tenure of four (4) years.

II. Reconsideration Process

A. If a specialty requests reconsideration, the Chairman will appoint an Ad Hoc Facilitation Committee as in I.G.3. If time permits, the RUC will hold the relevant portion of the final recommendation of the RUC while the reconsideration process continues.

B. The Ad Hoc Facilitation Committee shall meet in person or by telephone conference within two week of receipt of a written request for reconsideration.

C. All requests for reconsideration of RUC decisions shall be in writing.

D. The Ad Hoc Facilitation Committee shall invite requestors of reconsiderations to meet with the Ad Hoc Facilitation Committee in person or by telephone to discuss the rationale for RUC decisions or to provide written comments.

E. The Ad Hoc Facilitation Committee will notify anyone who previously commented of proposed reconsideration and elicit further comments.

F. The Ad Hoc Facilitation Committee shall vote to refer or not to refer a request for reconsideration to the RUC for reconsideration at least two weeks prior to the next meeting of the RUC and shall communicate to all relevant parties in a timely manner.

G. In the event the RUC reconsiders an action by this reconsideration process, the RUC decision will be final.

III. HCFA Communication and Implementation

A. All communications to HCFA of RUC recommendations shall be made by the RUC Chairman in writing with copies to RUC representatives.

B. It is envisioned that HCFA would review the RUC recommendations and would consider the recommendation during HCFA's process for promulgating relative values for Medicare services through official rule making procedure with notice and comment.

IV. Confidentiality and Proprietary Rights

A. All representatives to the RUC and participants in all committees within the Process acknowledge by their participation that any information and materials provided by the AMA or the RUC is confidential and/or proprietary information and shall be kept confidential by the representative and shall only be used by the representative and disseminated by the representative for internal use within their organization as provided for by the Process. Any other distribution of materials is strictly prohibited.

B. All representatives to the RUC and participants in all Committees within the Process acknowledge by their participation that all notices of copyright, confidentiality or other conditions on distributed materials shall not be removed from any materials.

C. Any materials including Current Procedural Terminology, Fourth Edition (CPT) must include the following copyright notice:

> Physician Current Procedural Terminology, Fourth Edition (CPT) only is copyright 1991 American Medical Association (or such other date as publication of CPT as defined in the federal copyright laws).

AMA may also include temporary internal numbers instead of final CPT code numbers in distributed materials.

PLCL:692

(d) Editorial Panel: The CPT Editorial Panel representative shall be a representative to the RUC for the same term as their tenure on the CPT Editorial Panel.

(e) After the first two years of existence of the RUC, the RUC shall adopt procedures to stagger the terms of RUC representatives.

(5) Voting:

(a) Representatives from the AMA, the AOA, and each specialty society shall each be entitled to one vote.

(b) The Chairperson shall only vote in the event of a tie vote.

(c) The representatives from the CPT Editorial Panel shall not be entitled to vote.

(6) Functions - RUC functions and responsibilities shall include, but not be limited to:

(a) Developing and approving the agenda for development of relative values for new or revised codes;
(b) Enhancing the methodology of the update process;
(c) Considering RVS update recommendations presented by Advisory Committee members on behalf of Specialty Society Committees and from other sources approved by the RUC;
(d) Chairing permanent and ad hoc committees
(e) Developing a cooperative research agenda; and
(f) Making formal recommendations to HCFA
(g) Notifying the CPT Editorial Panel of its actions as well as provide a report for future coding considerations of RUC deliberations associated with particular physician services and information the RUC obtains that bears on descriptions of medical services.

(7) Duty

(a) Specialty Society representatives shall execute independent judgment in their deliberations consistent with membership on the RUC.

(8) Quorum - Fifteen (15) representatives to the RUC shall constitute a quorum for the conduct of any business.

B. Advisory Committee

(1) Purpose - As requested, the Advisory Committee (AC) members shall provide technical resources to the RUC on update issues pertinent to each specialty member and will serve as a liaison with the Specialty Societies. In particular, each Advisory Committee member will serve as the formal liaison between the RVS Committee (referred to as Specialty Committees) established by his/or her specialty society and the RUC. As described in the "Rules and Procedures" I.D. these Specialty Committees will be responsible for developing relative value estimates using protocols and materials supplied by the RUC and AMA staff. The Advisory Committee shall not be a voting body. Although meetings of its entire membership may be convened by the chairman of the RUC, it is expected that its duties will be carried out through communications between the RUC and the pertinent Advisory Committee members.

(2) Composition - The AC shall be composed of a physician representative from each interested Specialty Society as represented in the AMA House of Delegates, plus other national medical specialty societies that the Chairman of the RUC designates to fill an identified need.

(3) Designation - Specialty Society representatives of the AC shall be designated by each respective Specialty Society. One alternate specialty society representative shall also be nominated by each of the Specialty Societies to participate on the AC in the absence of the respective Specialty Society representative. Specialty Society representatives, to the extent practicable, shall not be the same individual as the Specialty Society representative(s) to the RUC or a member of the CPT Editorial Panel or CPT Advisory Committee. The AMA shall approve all Specialty Society nominations to the AC.

(4) Terms of Appointment - (a) Specialty Society representative and alternates shall hold terms of three (3) years, with a maximum tenure of six (6) years.

(5) Functions - AC functions and responsibilities shall include but shall not be limited to:

a) Advising the RUC concerning the agenda for development of relative values for new or revised codes;
b) Identifying specialties affected by proposed relative value revisions;
c) Assisting with the cooperative research agenda;
d) Serving on subcommittees;
e) Providing advice on the update process; and
f) Serving as liaison with national medical specialty societies

(6) Duty

a) Specialty Society representatives shall exercise independent judgment in their deliberations consistent with participation on the AC.

C. Health Care Professional Advisory Committee

(1) Purpose - The Health Care Professional Advisory Committee (HCPAC) members shall provide the RUC with views and perspectives of the relevant non-MD/DO health care providers. The HCPAC shall not conduct votes. Although meetings of its entire membership may be convened by the chairman of the RUC, it is expected that its duties will be carried out through communications between the RUC and the pertinent HCPAC members.

(2) Composition - The HCPAC shall include _____ representatives and be composed of representatives of each national society representing relevant health care professionals who are non-physician providers. The societies include _____.

(3) Designation - The relevant National Societies for health care professionals who are non-physician providers may each designate a representative to the HCPAC, subject to the approval of the AMA.

(4) Term:

(a) Representatives to the HCPAC shall hold terms of three (3) years, with a maximum tenure of six (6) years.

(5) Functions - HCPAC functions and responsibilities shall include but shall not be limited to:

a) Commenting on proposed RVS changes;
b) Advising the RUC concerning the agenda for development of relative values for new or revised codes;
c) Identifying non-physician providers affected by any relative value revision;
d) Assisting with the cooperative research agenda;

e) Providing advice on the update process and;

f) Serving as liaison with the relevant national societies representing non-physician providers

D. Third Party Advisory Committee

(1) Purpose - The Third Party Advisory Committee (TPAC) to advise the RUC Chairperson on the perspectives and relevant data from major third parties. The TPAC shall not be a voting body. Although meetings of its entire membership may be convened by the chairman of the RUC, it is expected that its duties will be carried out through communications between the RUC and the pertinent TPAC members.

(2) Composition - The TPAC shall be composed of at least four (4) physician representatives and shall include a representative from each of the following: Health Care Financing Administration (HCFA), Medicare Carrier Medical Directors, the Blue Cross and Blue Shield Associations and the Health Insurance Association of America.

(3) Designation:

(a) TPAC representatives shall be designated by the respective third party organization.

(4) Terms of Appointment - TPAC representatives shall hold terms of two (2) years, with a maximum tenure of four (4) years.

(5) Functions - TPAC functions and responsibilities shall include but shall not be limited to:

a) Advising on the agenda for development of relative values for new or revised codes upon request;

b) Assisting with the cooperative research agenda;
c) Providing advice on the update process; and
d) Serving as liaison with the relevant third parties

E. Subcommittees

(1) Purpose - The Chairman of the RUC, from time to time shall form permanent and Ad Hoc Subcommittees to coordinate specific updating tasks.

(2) Composition - Each Subcommittee will have a permanent number of seats, will be chaired by an RUC member, and be comprised of members selected from the RUC, the AC and the HCPAC. Chairman and members of each Subcommittee to be selected by the RUC Chairman.

(3) Functions - The functions of each subcommittee shall be designated by the RUC and may include but shall not be limited to:

a) Overseeing specialty development of data (Research Subcommittee (see "Rules and Procedure" I.D.));
b) Accumulating data specific to updating activities;
c) Liaison with established AMA policy agendas;
d) Provide guidance for key AMA units and staff

F. Meetings

The RUC shall meet three (3) times per year or such other times as agreed to by the Chairperson and the AMA.

Other Committees and Subcommittees shall meet as agreed to by the Chairperson of the RUC.

All meetings shall be conducted according to Sturgis, Standard Code of Parliamentary Procedure.

A vote by two-thirds of the representatives present at each Committee or Subcommittee meeting shall constitute passage of each RVS recommendation in question or the adoption of or any amendment to these "Rules and Procedures" and/or "Structure and Functions;" and a simple majority vote of the representatives present at each Committee or Subcommittee meeting shall constitute passage of all other issues, subject to any approval by the AMA if required in this document. (See III A. 2., III. A. 3., III B. 3., III C. 3., III F, VIII. A. B.).

G. Officers

Chairperson - The AMA designated chairperson will preside at all RUC meetings. The AMA representative will be Vice Chairman and preside in the Chairman's absence.

Each other Committee or Subcommittee shall be chaired by a representative of the RUC as appointed by the Chairperson.

The AMA staff secretary representative shall take minutes of all RUC meetings.

A representative as designated by the chairperson of each Committee and Subcommittee of the Committee and Subcommittee shall take minutes at each meeting.

IV. FINANCIAL ASPECTS

A. All expenses of participating in the RUC or any Committee and Subcommittee shall be born by each representatives organization.

B. The AMA will provide agenda material, central staff support and meeting space and meeting meals at the AMA's expense.

V. LIAISON WITH THE AMERICAN MEDICAL ASSOCIATION (AMA)

A. Formal communications shall be directed to the AMA through the Chairperson.

B. Neither the RUC nor any other Committee or Subcommittee shall have the authority to direct the AMA to conduct work projects, products or research.

C. Approval by the AMA as referred to in this document shall mean approval by the AMA representative to the RUC (or the alternate representative in the absence of the representative) or approval by the Executive Vice President of the AMA.

VI. FINANCIAL INTEREST OF REPRESENTATIVES

A. No RUC or other Committee or Subcommittee representative will vote or participate in any deliberation on a specific issue in the event the representative has a financial interest in the outcome of the vote or deliberation other than the representative in the course of their practice performing the procedure or service at issue. Every RUC or other Committee or Subcommittee representative shall disclose his or her potential interest prior to any vote or deliberation and shall not vote or participate in the deliberation.

VII. CONTINUED REPRESENTATION

A. A representative's continued participation on the RUC and/or any other Committee or Subcommittee is contingent upon the representative complying with the requirements of this Structure and Organization document and the Rules and Procedures adopted by the RUC.

VIII. ADOPTION OF RULES AND PROCEDURE AND STRUCTURE AND FUNCTION OF THE AMA/SPECIALTY SOCIETY PROCESS TO DEVELOP RELATIVE VALUES FOR NEW OR REVISED CPT CODES

A. This document entitled Structure and functions of the American Medical Association/Specialty Society Relative Value Update Process shall be official when adopted by a two-thirds majority vote of the representatives present at a meeting of the RUC subject to the approval by the AMA. Any modification to this document shall be official when adopted by a two thirds majority vote of the representatives present at a meeting of the RUC and subject to the approval by the American Medical Association.

B. The RUC shall adopt Rules and Procedures for its Process to develop relative values for new or revised CPT codes. These Rules and Procedures shall be official when adopted by a two thirds vote of the representatives present at a meeting of the RUC subject to the approval of the American Medical Association. Any modification to the Rules and Procedures shall be official when adopted by a two-thirds majority vote of the representatives present at a meeting of the RUC subject to the approval of the American Medical Association.

PLCL:683

APPENDIX 3

AMA/SPECIALTY SOCIETY RVS UPDATING PROCESS: SURVEY INSTRUMENT

Instructions for Specialty Societies

Enclosed is the survey instrument that will form the basis of your development of recommendations for the physician work relative values for new or revised CPT codes provided by your specialty. The services to be rated are those for which you indicated a desire to develop information on physician work. (You are not being asked to comment on the new or revised codes or their descriptors.) These services are identified in the Questionnaire. These services will be rated using reference services drawn from a larger set of potential reference services identified by your society or other societies in your specialty. In addition, one or more reference services identified by your society as being particularly relevant for the new or revised codes being rated may be included in the Questionnaire. Table 1 of the Questionnaire includes the reference services that you will use.

PLEASE CONTACT SANDY SHERMAN (312-464-4723) OR MARK SEGAL (312-464-4726) IMMEDIATELY IF YOU HAVE QUESTIONS ABOUT ANY OF THESE SERVICES OR ANY OTHER ELEMENTS OF THESE MATERIALS.

Outlined below are the steps that you should follow in developing recommendations for the RVS Updating Committee (RUC). **Please read all of these steps before proceeding.** Please also refer to the March 5, 1992 and May 20 mailings from Grant V. Rodkey, MD, Chairman of the RUC for additional information.

Step 1: Form RVS Committee (Committee) for your society.

Where multiple societies exist for your specialty, we urge you to designate a joint RVS Committee. In addition, if other specialties are developing recommendations for the same codes you are surveying, we encourage you, if possible, to coordinate with these other specialties in conducting your survey and in developing your recommendations.

Step 2: Determine if your RVS Committee will provide sufficient expertise to rate the new or revised codes under consideration.

If not, you will want to augment this committee for the mail survey. You may also want to bring in additional members of your specialty for the RVS Committee meeting. Finally, you may choose to survey a large number of physicians (i.e., 100) to develop estimates that will have greater statistical validity.

Step 3: Distribute the Questionnaire to the physicians that have agreed to complete it.

You must contact these physicians prior to sending the questionnaire and determine that they have agreed to complete it. You will probably want to prepare additional explanatory material (e.g., a cover letter from your society). You may also want to develop an addendum to Table 2 of the Questionnaire that follows the indicated framework but is more specific about the detailed components of work for your specialty. You should also use this material to confirm the date, time, and place for the meeting of your RVS Committee to consider these codes. You should complete the blank spaces on the Introduction to the Questionnaire indicating to whom responses should be sent, when they should be returned, and identifying a specialty society contact person.

Step 4: Collect all responses to the Questionnaire.

Step 5: Summarize responses for your RVS Committee and your report to the RUC.

You should calculate the medians of the ratings of work provided by those physicians who completed the Questionnaire.

After arraying the individual scores from lowest to highest, the median is the rating below which 50% of the ratings fall (i.e., the 50th percentile). For an odd number of ratings, the median is the rating that is in the middle of the range of scores. For an even number of ratings, the median is the rating that is halfway between the two middle ratings.

You should also wish prepare a frequency distribution of the rating, identifying the 25th and 75th percentiles.

Finally, you should evaluate whether certain factors may have influenced ratings. Such factors might include practice setting, typical patient for whom the code is used and particular assumptions used in making ratings (see rating form), and familiarity with the service being rated (see rating form).

Step 6: Convene your RVS Committee to consider the results of the survey and finalize its recommendations.

The meeting should be led by either a committee member or staff person who is comfortable leading groups and who is familiar with this process and its materials.

The survey results, including median scores, should be considered starting points for the deliberations of the committee. The discussion for each rating should follow the approach of the Questionnaire. Members should place each new or revised code in the appropriate place in the list of reference services in Table 1 of

the Questionnaire. The committee should agree from the outset on the scope and nature of the services identified with the new code. Your RVS Committee should focus on arriving at an estimate of physician work that applies to the average patient seen by physicians using this service.

As with the mail responses, members should identify those reference services whose comparisons with existing codes were most important. In addition, the discussion should be explicit about why a particular new or revised code should be placed where it is. The clinical basis for these ratings should be identified, as well as the specific time and work relationships between the surveyed services and the reference services, including time and work involved before, during, and after the services or procedures.

The committee should identify and discuss the sources of any disagreement within the committee (e.g., region of practice, nature of patient population, training site, etc.). Remaining substantive disagreements should be conveyed to the RUC. The committee should also identify and provide a rationale for situations where its work estimates diverge from those obtained during the survey phase. If possible, the committee should also identify and provide a rationale for situations where its work estimates differ from those of other specialties surveying the same code(s).

Step 7: Identifying Intercode Work Relationships

THIS STEP IS OPTIONAL AND SOLELY AT THE DISCRETION OF THE SPECIALTY

Cross-Walks: As appropriate, the Specialty RVS Committee should use Attachment 1 to establish a "cross-walk" between current CPT codes and the new or revised codes. This cross-walk can be used in estimating volume for new or revised codes.

"Intercode Work Relationships": The Specialty RVS Committee may identify current CPT codes whose volume and/or physician work will be affected by each new or revised code. Codes whose average work is likely to have been altered by the coding change will have been included in the Questionnaire for rating. Where this was not done, the committee may identify such codes and rate them itself.

The Specialty RVS Committee may further determine that the total amount of physician work associated with a particular set of new or revised codes should be equivalent to that for a particular set of current codes. Such a determination takes into account both the frequency with which a service is provided as well as its work value. Examples where such a determination might be made are:

One code is split into two codes, with no increase in the total amount of physician work associated with these services. For example, a single code formerly described a procedure performed "with or without" a second proce-

dure and two codes have now been developed, one for "with" and one for "without" the second procedure.

Two current codes are split into four codes, with no increase in the total amount of physician work associated with these services. For example, a single code has been split into four codes specifying the lesion size and body site.

Where it believes that a coding change fits into one of these categories, the Specialty RVS Committee may recommend changes in the work values of the relevant current codes to reflect changes in work that might come from such changes. In general, any such considerations of intercode work relationships should come into play only after work estimates for all affected services have been developed. In addition to rating the relevant services, two additional methods may be used by the Specialty RVS Committee, at its discretion, to evaluate the extent to which the total work for the new values (i.e., the work RVUs for each service multiplied by the volume for each service) are equivalent to the total work for the old codes and to identify any adjustments that the Specialty RVS Committee may wish to apply:

First, cross-walks developed using from Attachment 1 can be used to adjust values of current codes using the work values and information on what proportion of the services associated with the old code will now be coded with the new code (e.g., if the new code is now used for higher than average services formerly coded with the old code). See Attachment 2 for example.

Alternatively, the committee may use an "intercode work relationship" program developed for Lotus 1-2-3 and furnished by the AMA to adjust the relative values for a number of related services affected by the code change. This program will also require cross-walk information and may need volume data, which will be furnished by the AMA. This program can also be used to verify that the results of the first approach are equivalent in total work to the old work associated with the code(s). **Please contact Mark Segal at the AMA (see p. 1) to obtain this program. When contacting Dr. Segal, please furnish a list of all potentially affected codes.**

Any judgments about whether a specialty recommendation should consider these intercode work relationships will be up to the affected specialty societies. Only if the society believes that the new work estimates should equal the old work would they make any adjustments. Moreover, the type of adjustment would essentially be up to the specialty society. To use the example on page 6, it may be no more than surveying both "revised Code a" and "Code b." **There is no intention to reduce appropriate relative work estimates solely to meet an external constraint.** If a specialty feels that a coding change should not be subject to such a constraint, it is free to make such recommendations to the RUC. In certain circumstances, of

course, the RUC may question your Advisory Committee member on this issue but there will be no presumption regarding the intercode work relationships of most specialty RVS recommendations.

Step 8: The Specialty RVS Committee finalizes its recommendation.

Prepare a brief report that includes ratings of new or revised codes, documentation of the process and reasoning used in making these ratings, results of the mail survey, and any other information the RUC should consider in evaluating your recommendation.

Step 9: Your Advisory Committee member should transmit the recommendation (including the report prepared for Step 8) of your RVS Committee to the RUC by June 15.

Step 10: After contacting you for any needed clarifications, these recommendations will be sent to the RUC and to interested specialties by June 18.

Step 11: The RUC will meet to consider this recommendation on June 25-27.

Your advisor should be prepared to make a brief presentation of your recommendation and to answer any questions by RUC members. The agenda for the RUC meeting should be completed and distributed by June 15. Your advisor should plan to be available for more than one day of the RUC meeting in the event that your recommendations are discussed a second time during the meeting. Please contact Shelia Coleman at (312) 464-4514 as soon as possible if you will require Hotel reservations. The meeting will be held at the Sheraton Chicago Hotel and Towers, 301 East North Water Street, Chicago, IL 60611 (312) 464-9140.

Attachment 1: ESTIMATING VOLUME FOR NEW CPT CODES

The chart below provides a framework for estimating cross-walks between old and new codes (i.e., the proportion of the services reported with each existing code to be reported with the relevant new code. In this example, 50% of services previously reported with code "a" will now be reported with new code "A" and 50% with new code "B." Likewise, code "D" will include services reported with old codes "c", "d", and "e." Upon request, the AMA will supply frequency data from Medicare BMAD files. **You should supply your best estimate of percentages with which the services reported with existing codes will be reported with new codes.** The next page contains a master cross-walk form for your duplication and use.

1992 Codes	**1993 CPT Codes** *Percent of Times Old Code Replaced by New Code*					
	new code A	new code B	new code C	new code D	new code E	Total for New Code
code a	.50	.50				1.00
code b		.70	.30			1.00
code c			.60	.40		1.00
code d				.67	.33	1.00
code e				.25	.75	1.00

Cross-walk Between Old and New Codes: Master Form

1992 Codes	1993 CPT Codes *Percent of Times Old Code Replaced by New Code*					
	new code	new code	new code	new code	new code	Total for New Code
						1.00
						1.00
						1.00
						1.00
						1.00
						1.00
						1.00
						1.00

The table below provides an example of a situation where a new code (code "b") is added to CPT and used to report some portion (i.e., 20%) of the services previous reported with code "a." Code "a" will continue to be used for 80% of the service for which it was previously used. In this approach, the value for code "b" is established through the normal survey procedure. Rather than estimating the value of the revised code "a" as well, its "work neutral" value is assigned by use of an equation that solves for the average work value attached to the remaining services reported with code "a."

> That is, if the work value of the original code "a" was 100, and the work value of the new code "b" is estimated to be 110, the value of the services continuing to be reported with code "a" is 97.5.

The advantage of using this approach is two-fold. First, it reduces the number of services that must be rated by magnitude estimation. Second, it does not alter the value established for the new code "b" due to arbitrary constraints.

The disadvantage is that it does not allow physicians to actually rate new code "a" and substitutes algebra for physician judgment.

Specialty RVS committees may want use both this method and the AMA-supplied intercode work relationship software in the final development of work estimates for closely related codes for which such constraints are felt to apply.

1992 Codes	1993 Codes		
	Code a	Code b	Total
Code a (Work=100)	.80	.20	1.00
		Work =110	
Non-Work Equivalent	.8x100=80	.2x110=22	102
Work Equivalent (Assumes "Code a" value reduced as higher value services now use "Code b" - Original value of "Code a" is reference)	.8x97.5*=78	.2x110=22	100

*100 = .8x * .2(110), x="Code a" value given "Code b"
x=97.5
=work neutral value of revised "Code a"

Neurology/American Academy of Neurology Date: June, 1992

AMA/SPECIALTY SOCIETY RVS UPDATING PROCESS: SURVEY INSTRUMENT

INTRODUCTION

The purpose of this survey is for you to rate the relative amount of physician work associated with one or more new or revised CPT codes. These codes are listed in the next section.

You have been selected to complete this survey by your specialty society, which is participating in the AMA/Specialty Society RVS Updating Process. The results of this survey will be considered by a committee of your specialty society as it develops a recommendation on estimates of physician work for these services. This recommendation will be reviewed by the AMA/Specialty Society RVS Update Committee (RUC) which in turn will make a recommendation to the Health Care Financing Administration (HCFA). HCFA will consider this recommendation as it updates the new Medicare Payment Schedule (also called the Medicare Fee Schedule) for 1993.

You will use magnitude estimation. In this method, the work of selected services is used as a series of reference points for you to evaluate the work of each new or revised code under review. These reference services are from the new Medicare Payment Schedule and are listed in Table 1. Physician work includes the time it takes to perform the service as well as the three dimensions of the intensity of that time -- technical skill and physical effort, mental effort and judgement, and stress associated with your concern about iatrogenic risk.

First, you will provide estimates of the physician work associated with new or revised CPT codes used by your specialty. Next, you will identify the typical patient to whom you provide the services identified with each code as well as any special assumptions that you made in rating the service. Finally, you will provide information on the frequency with which you provide the service associated with each code.

By _____, please return your completed survey to:

_____

_____

_____

_____

If you have any questions, please contact:

Physician Name: _____

Work Ratings for New or Revised CPT Codes

Estimating Total Work: We first ask you to estimate the total work for each service. Total work encompasses the actual period spent performing the service as well as related work before and after the service. Please refer to Table 2 for a detailed description of each of the components of total work. Although you are only being asked about total work, please consider all of the applicable individual components of total work. In addition, consider the specific global service period associated with each new/revised code and each applicable reference service. These global periods are from the Medicare Payment Schedule. For new codes, the best estimate of the global period likely to be assigned by HCFA is provided.

Reference Services: To assist you in estimating work, we have selected a number of reference services provided by physicians in your specialty (Table 1). These include services that are clinically similar to those that we will ask you to rate as well as other commonly performed services in your specialty that cover a broad range of physician work. These latter services were chosen in cooperation with your specialty society. They are services from the Medicare Payment Schedule that can be used as reference services for this project because they are sufficiently accurate and stable, at least within broad categories of services (e.g., major surgery). Inclusion in this list does not mean that your specialty society may not also be pursuing refinement of these values with HCFA.

Rating Services: If the service involves twice as much work as a particular reference service, assign it a value equal to twice the work of that service. If you think that the service involves half as much work as the reference service, assign it a value equal to half the work of that service, and so on. In estimating the physician work associated with a service, please consider the time it takes to perform the service as well as the three dimensions of the intensity of that time -- technical skill and physical effort, mental effort and judgement, and stress associated with your concern about iatrogenic risk.

In all cases, please respond in terms of your average patient. In general (using the code in question) this should be the typical patient that you would see. At the same time, in formulating your estimates, please consider the extent to which your patients for which this code is used require either more or less work than your typical patient. Please do not allow your answers to be unduly influenced by unusual or atypical patients.

Please rate the work for the services listed below using the reference services and their work values in Table 1 as a guide. We anticipate that the mos: important comparisons will be to clinically similar services where many of the components of the services (e.g., follow-up care) will be the same or similar. Do not change the work values for any of the reference services. In some instances where you are asked to rate more than one code, you may find it easiest to first establish an overall rank order for the services listed below as well as the relationship of the work of each service to its adjacent services.

It is very important that you complete the column headed "Key Reference Services in Priority Order" by filling in the reference services that you found most useful in estimating relative work. If the physician work relative values assigned to these codes are adjusted for the 1993 Medicare Payment Schedule, we will adjust the list of reference services as appropriate.

Experience with New or Revised Codes: You may not have recent experience with any or all of the services to be rated. We do ask that you provide ratings for those services about which you have recent and direct professional knowledge and feel comfortable answering, whether or not you currently perform the service. For those services for which you do not provide an estimate, please enter the letters "NR."

Given the total work values for the selected services for your specialty shown in Table 1, what number would you assign to the total work for each of the services listed below? Again, please consider the detailed definition of the components of total work on Table 2 as well as the global periods in Table 1 and for each service below. Please also indicate, in priority order, those services from Table 1 that were important reference services for each service below (Use the number in column #1).

Next, please provide a brief description of the typical patient that you would expect to treat using the code and/or the nature of the services that you would expect to provide. Please also identify any special assumptions (e.g., associated procedures used) that you made in rating the code.

Finally, please indicate the number of times that you provided the service in the past twelve months.

NEUROLOGY: American Academy of Neurology

New or Revised CPT Codes

Tracking Number	CPT Code	CPT Descriptor	Type of Revision	Work RVUs (X 100)	Global Period**	Key Reference Services in Priority Order	Typical Patient and Nature and Extent of Services Provided – Including any Special Assumptions You Made Rating the Service	About How Many Times in the Last 12 Months Have You Provided This Service?	If Zero, How Many Times Have you Provided the Service in Your Career?
218	615XX•	Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring	A new code added for insertion of brain electrodes for epilepsy; removal of electrodes included in code		090				
219	615XX•	Stereotaxic implantation of depth electrodes into the cerebrum for long term seizure monitoring	New code added for insertion of brain electrodes for epilepsy; removal of electrodes included		090				
220	61533	~~Craniectomy, trephination, bone flap~~ Craniotomy with elevation of bone flap for subdural implantation of an ~~for insertion of epidural or subdural~~ electrode array for long term seizure monitoring	Code modified to indicate craniotomy and insertion of brain electrodes for epilepsy (No change in intent of code)		090				
262	958XX•	Neuropsychological testing with report, per hour (eg, LURIA, Halstead battery, WAIS)	A new code added for neuropsychological testing (e.g., LURIA, Halstead battery, WAIS, etc.)		XXX				
263	95950	Monitoring for ~~localization~~ identification and lateralization of cerebral seizure focus by attached electrodes ~~or radiotelemetry~~, electroencephalographic (8 channel EEG) recording and interpretation, each ~~initial~~ 24 hours	Code modified to exclude localization so that it is solely used for ambulatory cassette (8 channel) EEG		XXX				

Tracking Number	CPT Code	CPT Descriptor	Type of Revision	Work RVUs (X 100)	Global Period**	Key Reference Services in Priority Order	Typical Patient and Nature and Extent of Services Provided – Including any Special Assumptions You Made Rating the Service	Actual How Many Times in the Last 12 Months Have You Provided This Service?	If Zero, How Many Times Have you Provided the Service in Your Career?
264	95951	combined electroencephalographic (EEG) and video recording and interpretation, each initial 24 hours	Code 95951 modified to account for each 24 hour period rather than the initial 24 hours		XXX				
266	959XX•	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG; electroencephalographic (EEG) recording and interpretation, each 24 hours	A new code added for monitoring for localization of cerebral seizure focus		XXX				
267	959XX•	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry; electroencephalographic (EEG) recording and interpretation, each 24 hours	A new code to be added for monitoring for localization of cerebral seizure focus		XXX				

**A service paid on a global basis includes visits and other services provided in addition to the basic procedure during a specified number of days before and after the procedure is provided. The *global period* identified above refers to the number of preprocedural and postprocedural days of care that are included in the payment for a global surgical package as determined by the Health Care Financing Administration for Medicare payment purposes. There are three categories of global services (090, 010, 000). In addition, there are two types of alpha global codes that may be used:
XXX=Global concept does not apply to the code; YYY=Global period is to be set by the Medicare carrier; ZZZ=Code is part of another service and falls within the global period for the other service.
Refer to Table 2 for the services included in each type of global package.

A "separate procedure" is one that is commonly carried out as an integral part of a total service and thus not generally identified separately. In those instances, however, when such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure."

Final assignments of codes and code descriptors are subject to change by the CPT Editorial Panel prior to publication of *CPT 1993*. The information contained in this questionnaire is confidential and proprietary and should only be used pursuant to participation in the AMA/Specialty Society RVS Update Process.

Table 1
NEUROLOGY
American Academy of Neurology

Reference Services

Number	Procedure	CPT DESCRIPTOR	Work RVUs (x 100)	Global Period
1	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	21	XXX
2	95819-26	electroencephalogram (eeg) including recording awake and asleep, with hyperventilation and/or photic stimulation; standard or portable, same facility	39	XXX
3	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	40	XXX
4	95823	electroencephalogram (eeg); physical or pharmacological activation only	45	XXX
5	95925	somatosensory testing (eg, cerebral evoked potentials), one or more nerves	53	XXX
6	99241	office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	59	XXX
7	93880	duplex scan of extracranial arteries; complete bilateral study	64	XXX
8	99272	Confirmatory consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity.	91	XXX
9	95860	electromyography; one extremity and related paraspinal areas	101	XXX

Number	Procedure	CPT DESCRIPTOR	Work RVUs (x 100)	Global Period
10	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.	114	XXX
11	62270	spinal puncture, lumbar, diagnostic	118	000
13	99273	Confirmatory consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	128	XXX
14	99243	Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.	156	XXX
15	95861	electromyography; two extremities and related paraspinal areas	163	XXX
16	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.	168	XXX
17	99244	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.	229	XXX
18	63047	laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis), single vertebral segment; lumbar	1,344	090

*Note: These work RVUs are taken from the Medicare Payment Schedule published in the Federal Register on November 25, 199 They have been multiplied by 100 to assist the rating process.

A service paid on a global basis includes visits and other services provided in addition to the basic procedure during a specified n of days before and after the procedure is provided. The *global period* identified above refers to the number of preprocedural and postprocedural days of care that are included in the payment for a global surgical package as determined by the Health Care Finan Administration for Medicare payment purposes. There are three categories of global services (090, 010, 000). In addition, there are two types of alpha global codes that may be used: XXX=Global concept does not apply to code; YYY=Global period to be set by th Medicare carrier; ZZZ=Code is part of another service and falls within global period for other service. Refer to Table 2 for the services included in each type of global package.

A "separate procedure" is one that is commonly carried out as an integral part of a total service and thus not generally identified separately. In those instances, however, when such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure."

Table 2

Components of Physicians' Total Work

IN EVALUATING THE WORK OF A SERVICE, IT IS HELPFUL TO IDENTIFY AND THINK ABOUT EACH OF THE COMPONENTS OF A PARTICULAR SERVICE. FOCUS ONLY ON THE WORK THAT YOU PERFORM DURING EACH OF THE IDENTIFIED COMPONENTS. THE DESCRIPTIONS BELOW ARE GENERAL IN NATURE. SPECIFIC COMPONENTS WILL VARY BY SPECIALTY AND SPECIFIC SERVICE. (YOUR SPECIALTY MAY HAVE DEVELOPED A MORE SPECIFIC LISTING OF POTENTIAL SERVICES WITHIN EACH COMPONENT.) WITHIN THE BROAD OUTLINES PRESENTED, PLEASE THINK ABOUT THE SPECIFIC SERVICES THAT YOU PROVIDE.

PHYSICIAN WORK INCLUDES THE TIME IT TAKES TO PERFORM THE SERVICE AS WELL AS THE THREE DIMENSIONS OF THE INTENSITY OF THAT TIME -- TECHNICAL SKILL AND PHYSICAL EFFORT, MENTAL EFFORT AND JUDGEMENT, AND STRESS ASSOCIATED WITH YOUR CONCERN ABOUT IATROGENIC RISK.

	Work During the Service Is	Before the Service, May Include	After the Service, May Include
Major Surgery	Work while you perform the service -- "skin-to-skin" work -- including all intra-operative services that are normally included as a necessary part of the procedure.	Services provided within 24 hours of the operation: Hospital admission work-up. Pre-operative evaluation, including procedural work-up; communicating with other professionals, patient and family; and obtaining consent -- frequently overlaps with admission work-up **(excluding consultation or evaluation at which the decision to provide the procedure was made).** Other pre-operative work, including consultations scrubbing and waiting before surgery, preparing patient and needed equipment for surgery, and positioning the patient and other non "skin-to-skin" work in the OR.	Post-operative care on day of the procedure, including non "skin-to-skin" work in the OR, including patient stabilization; communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits -- includes care for inpatients and outpatients. Patient stabilization in the recovery room or special unit. Other follow-up care before the patient is discharged, if applicable. Post-operative visits within 90 days of the operation (See below for pre- and post-service work associated with visits).

	Work During the Service Is	Before the Service, May Include	After the Service, May Include
Minor Surgery and Endoscopies	Work while you perform the service -- "skin-to-skin" work -- including all services that are normally included as a necessary part of the procedure.	On day of procedure: Pre-procedural work, including procedural work-up; communicating with other professionals, patient and family; obtaining consent; and preparing patient and equipment and scrubbing and waiting before procedure, and positioning patient and other non "skin-to-skin" work. **Excludes:** **Consultation or evaluation at which decision to provide procedure was made**, and Distinct evaluation and management services provided in addition to procedure (reported with modifier -25).	Post-procedure visits on the day of the procedure (0) or within 10 days of the procedure as listed in Table 1 (See also information below on pre- and post-service work for visits).

	Work During the Service Is	Before the Service, May Include	After the Service, May Include
Evaluation/ Management Services			
Office	Work while you are with the patient and/or family.	Preparing to see patient. Reviewing records. Communicating with other professionals.	Arranging for further services. Reviewing results of studies. Communicating further with patient, family, and other professionals, including written and telephone reports.
Hospital	Work while you are present on the patient's hospital unit or floor, including: Reviewing the patient's chart. Seeing the patient. Writing notes. Communicating with other professionals and the patient's family	Work while not present on the patient's hospital unit or floor, including: Communicating further with other professionals and the patient's family. Obtaining and/or reviewing the results of diagnostic and other studies. Written and telephone reports.	Work while not present on the patient's hospital unit or floor, including: Communicating further with other professionals and the patient's family. Obtaining and/or reviewing the results of diagnostic and other studies. Written and telephone reports.

	Work During the Service Is	Before the Service, May Include	After the Service, May Include
Laboratory and Imaging and other non-Evaluation/ Management Services with XXX global period	For these services, the service period is treated as a whole and includes the work from the time you begin the service until you complete it and report your results, if applicable. Consider only the work that you do and not work done by technicians or other professionals. Do not include distinct evaluation and management services provided in addition to procedure in your estimate.		
Emergency Medicine			
Invasive	Work for the total service period may include: Reviewing records, obtaining and interpreting test results or X-rays, and preparing to perform the service. Performing the service. Providing immediate postprocedural care before the patient is discharged or admitted to the hospital. Communicating with the patient, patient's family, or other professionals. Completing charts.		

	Work During the Service Is	Before the Service, May Include	After the Service, May Include
Evaluation /Management	Work for the total service may include: Obtaining and reviewing records and interpreting test results or X-rays. Seeing the patient. Communicating with the patient, patient's family, or other professionals. Completing charts.		
Nuclear Medicine			
Imaging	The service period includes the time spent working on the service from the time you begin the service until you report your results. Please consider only the work that you do and not work done by technicians and other professionals. In particular, please do not consider the work involved in scanning the patient if you do not perform this task.		
Evaluation /Management Services	See above definition for these services.		
Radiation Oncology	Includes: clinical treatment planning, simulation-aid field testing, dosimetry and design of treatment devices, and clinical treatment management. For these services, the service period is treated as a whole and includes the work from the time you begin the service until you complete it and report your results, if applicable. Consider only the work that you do and not work done by technicians or other professionals.		
Diagnostic Imaging Services	For these services, the service period is treated as a whole and includes the work from the time you begin the service until you complete it and report your results, if applicable. Consider only the work that you do and not work done by technicians or other professionals.		

ATTACHMENTS

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

American Society of Anesthesiologists - Report to Relative Value Update Committee

June 1992

1. Anesthesia Services under the MFS
2. Survey Process
3. New CPT Code
   descriptor
   work value
   reference codes

1. Anesthesia Services Under the Medicare Fee Schedule

The American Society of Anesthesiologists has developed, published and maintained a Relative Value Guide (RVG) since 1962. The ASA RVG assigns base units to the approximately 250 anesthesia codes. The base unit relative values are combined with units reflecting the actual time the anesthesiologist spends with the patient; each of these components is defined, by both the ASA and Medicare, as follows:

> The base unit value includes the value of all usual anesthesia services except the time actually spent in anesthesia care and the modifying factors.[1] The Basic Value includes usual pre-operative and post-operative visits, the administration of fluids and/or blood incident to the anesthesia care and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry).
>
> Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

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[1] The Medicare Program does not recognize modifying units for age or physical status.

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ATTACHMENT 2

The American College of Obstetricians and Gynecologists

June 17, 1992

Mark Segal, MD, Director
Health Care Financing and Organization
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Segal:

The American College of Obstetricians and Gynecologists (ACOG) is pleased to transmit to the Relative Value Update Committee its recommendations for relative work values for new and revised codes. Enclosed are detailed summaries of our survey results and the process used to develop our recommendations.

In addition, ACOG's RUC Committee concurs in the revised work estimate of 4.85 RVUs for CPT code 583XX, transcervical fallopian cannulization (any method), which was proposed by the American College of Radiology and the Society of Cardiovascular and Interventional Radiology.

Please call Shelah Leader (202) 863-2570 if you have any questions. Larry Griffin, MD, will present ACOG's recommendations of the June RUC meeting.

Sincerely,

John J. Graham, MD, FACOG
Director, Program Services

cc: W. Benson Harer, MD
Larry Griffin, MD
Shelah Leader, PhD

409 12th Street, SW, Washington, DC 20024-2188 (202)638-5577

SUMMARY OF SURVEY R.

CPT Code and Descriptor:

11975 - Insertion, implantable contraceptive capsules

Survey Sample: 35

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	16 (46%)	16 (46%)
Median	1.5	1.5
25th Percentile	1.03	1.03
75th Percentile	2.29	2.29
Low	.1	.1
High	6.64	6.64

Key Reference Services Used (ranked by number of mentions)

58300 (9)* insertion of IUD (1.06 RVUs)
58120 (4) 58301 (3) 24200 (2) 99213 (2) 20670 (1) 58720 (1)
99231 (1) 99232 (1)

Assumptions About Typical Patient (ranked by number of mentions)

Aged 15-44 (5)
Already informed/consented (5)
Contraceptive counsel (5)
Exam (1)

Assumptions About Nature of Service (ranked by number of mentions)

Respondent Experience with Procedure (frequency within past year)

Median	55
25th Percentile	26
75th Percentile	149
High	350
Low	5

RUC Recommendation: 1.50 RVUs

ACOG's RUC Committee believes this code entails more work than the reference service and that the survey median is reasonable.

SUMMARY OF SURVEY RESULTS

ATTACHMENT 2b (#182)

CPT Code and Descriptor:

XXXXX - Laparoscopy, surgical; with removal of leiomyomata

Survey Sample: 24

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	15 (63%)	6 (25%)
Median	10	13.75
25th Percentile	6.5	8.01
75th Percentile	18	18.5
Low	4.5	6
High	20	20

Key Reference Services Used (ranked by number of mentions)

58140 (8)
58988 (5)* laparoscopy, surgical; with removal of adnexal structures (5.89 RVUs)
58980 (3) 58985 (2) 58150 (1) 58260 (1) 58285 (1) 58720 (1)
58986 (1)

Assumptions About Typical Patient (ranked by number of mentions)

(Subcerosal) fibrosis (4)
Preserve uterine function (1)

Assumptions About Nature of Service (ranked by number of mentions)

Respondent Experience with Procedure (frequency within past year)

Median	.5
25th Percentile	0
75th Percentile	7
High	30
Low	0

RUC Recommendation: 5.89 RVUs

ACOG's RUC Committee believes the reference service is 58988 and that the work for the two codes is the same. They therefore recommend using the same RVUs for both codes.

CPT Code and Descriptor:

566XX - Vulvectomy, radical partial; with unilateral inguinofemoral lymphadenectomy

Survey Sample: 29

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	15 (52%)	11 (38%)
Median	16	16
25th Percentile	14	14
75th Percentile	25	27.38
Low	12.5	12.5
High	35	35

Key Reference Services Used (ranked by number of mentions)

56635 (8)* vulvectomy, radical; without skin graft with inguinofemoral lymphadenectomy (14.37 RVUs)
56630 (6)* vulvectomy, radical; without skin graft (12.07 RVUs)
58150 (4)
56640 (3)

Assumptions About Typical Patient (ranked by number of mentions)

Elderly (60+) patient w/associated medical problems (8)
early vulvarian cancer (5)

Assumptions About Nature of Service (ranked by number of mentions)

post-op visits (7)

Respondent Experience with Procedure (frequency within past year)

Median	3
25th Percentile	1
75th Percentile	6
High	12
Low	0

RUC Recommendation:

16.00 RVUs based on the survey median

CPT Code and Descriptor:

566XX - Vulvectomy, radical (tissue) complete

Survey Sample: 29

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	14 (48%)	7 (24%)
Median	14	15
25th Percentile	12	14
75th Percentile	18	20
Low	8.54	12
High	22	22

Key Reference Services Used (ranked by number of mentions)

56630 (8)* vulvectomy, radical; without skin graft (12.07 RVUs)
56635 (4)* vulvectomy, radical; with inguinofemoral lymphadenectomy (14.37 RVUs)
56625 (3) 58150 (3) 56620 (1) 58260 (1) 58270 (1)

Assumptions About Typical Patient (ranked by number of mentions)

Elderly (60+) patient w/medical problems (8)
Invasive cancer (3)

Assumptions About Nature of Service (ranked by number of mentions)

Post-op visits (6)

Respondent Experience with Procedure (frequency within past year)

Median	2
25th Percentile	0
75th Percentile	3
High	5
Low	0

RUC Recommendation:

14.00 RVUs based on the survey median

CPT Code and Descriptor:

566XX - Vulvectomy, radical, complete with unilateral inguinofemoral lymphadenectomy

Survey Sample: 29

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	15 (52%)	8 (28%)
Median	18	16.12
25th Percentile	14.5	14.37
75th Percentile	27.38	17.75
Low	13.5	13.5
High	38	32

Key Reference Services Used (ranked by number of mentions)

56635 (10)* vulvectomy, radical; with inguinofemoral lymphadenectomy (14.37 RVUs)
56640 (5)* vulvectomy, radical, with inguinofemoral, iliac, and pelvic lymphadenectomy (18.48 RVUs)
56630 (4) 58150 (4)

Assumptions About Typical Patient (ranked by number of mentions)

Elderly (60+) patient w/medical problems (10)
Invasive carcinoma (4)

Assumptions About Nature of Service (ranked by number of mentions)

Post-op visits (5)
Long hospital stay (2)

Respondent Experience with Procedure (frequency within past year)

Median	2
25th Percentile	0
75th Percentile	4
High	6
Low	0

RUC Recommendation:

18 RVUs based on the survey median

CPT Code and Descriptor:

574XX - Removal of embedded or impacted vaginal foreign body (separate procedure) under anesthesia

Survey Sample: 24

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	17 (71%)	3 (13%)
Median	1.5	.96
25th Percentile	1	.64
75th Percentile	2.5	1
Low	.64	.64
High	7.5	1

Key Reference Services Used (ranked by number of mentions)

57410 (10)* Pelvic exam under anesthesia (0.6 RVUs)
57400 (8) 99213 (2) 57452 (1) 58120 (1) 99232 (1)

Assumptions About Typical Patient (ranked by number of mentions)

Bleeding (2)
Unnatural foreign body (2)
Sedated virgin for vaginal exam or tampon (2)
Victim of assault (1)

Assumptions About Nature of Service (ranked by number of mentions)

Respondent Experience with Procedure (frequency within past year)

Median	0
25th Percentile	0
75th Percentile	1
High	5
Low	0

RUC Recommendation:

The ACOG recommends 0.96 RVUs, the median response of those surveyed. Unlike the key reference service, 57410, this service may include extensive counseling of a traumatized patient and a post-op visit. The added work is reasonably close to the median value.

SUMMARY OF SURVEY RESULTS

CPT Code and Descriptor:

574XX - Colposcopy (vaginoscopy); with loop electrosurgical excisions of the cervix (LEEP)

Survey Sample: 41

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	23 (56%)	19 (46%)
Median	2.98	2.98
25th Percentile	1.94	1.94
75th Percentile	3.92	3.92
Low	1.34	1.34
High	7.5	7.5

Key Reference Services Used (ranked by number of mentions)

57452 (10) 57510 (9) 57513 (9) 57511 (7)
57454 (5)* Colposcopy with biopsies or biopsy of cervix (1.34 RVUs)
57520 (5)* Conization of cervix (3.60 RVUs)
99213 (2) 58120 (1) 99212 (1) 57152 (1)

Assumptions About Typical Patient (ranked by number of mentions)

Abnormal lesion of cervix (17) CIN (4) Any age (3)

Assumptions About Nature of Service (ranked by number of mentions)

Respondent Experience with Procedure (frequency within past year)

Median	20
25th Percentile	5
75th Percentile	40
High	300
Low	0

RUC Recommendation: 2.98 RVUs based on the survey median.

ACOG's RUC Committee believes this new code falls between the reference services 57454 (1.34 RVUs) and 57520 (3.60 RVUs). Since an average of those RVUs is 2.47 RVUs, the Committee agreed that the survey median is reasonable.

SUMMARY OF SURVEY RESULTS

CPT Code and Descriptor:

582XX - Vaginal hysterectomy with removal of tube(s) and/or ovary(ies)

Survey Sample: 36

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	25 (69%)	20 (56%)
Median	14.5	14.62
25th Percentile	13.5	13.5
75th Percentile	16	15.96
Low	12.74	12.74
High	38	25

Key Reference Services Used (ranked by number of mentions)

58260 (12)* vaginal hysterectomy, with or without removal of tube(s), with or without removal of ovary(ies) (12.74 RVUs)
58150 (9) 58270 (7) 58267 (4) 58720 (4) 58120 (3) 58275 (2)
99231 (2) 99213 (1) 99232 (1)

Assumptions About Typical Patient (ranked by number of mentions)

Middle-aged (30-55) (10) Fibrosis (1)
Menorrhagia (3)
Pelvic pain (3)

Assumptions About Nature of Service (ranked by number of mentions)

Difficult to remove ovaries (3)

Respondent Experience with Procedure (frequency within past year)

Median	4.5
25th Percentile	2
75th Percentile	12
High	30
Low	0

RUC Recommendation:

14.5 RVUs based on the survey median

CPT Code and Descriptor:

582XX - Vaginal hysterectomy with removal of tube(s) and/or ovary(ies) with repair of enterocele

Survey Sample: 36

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	23 (64%)	18 (50%)
Median	16	15.5
25th Percentile	14	14
75th Percentile	18	18
Low	12.74	12.74
High	45	45

Key Reference Services Used (ranked by number of mentions)

58270 (9)* vaginal hysterectomy, with or without removal of tube(s), with or without removal of ovary(ies) with repair of enterocele (13.28 RVUs)

58260 (8)	58150 (7)	58150 (7)	58267 (5)	58280 (4)	58720 (3)
58120 (2)	58275 (2)	99231 (1)	99232 (1)	99213 (1)	

Assumptions About Typical Patient (ranked by number of mentions)

Middle-aged to old (14) Prolapse (4) Menorrahia (2)

Assumptions About Nature of Service (ranked by number of mentions)

Difficult procedure (3)

Respondent Experience with Procedure (frequency within past year)

Median	5
25th Percentile	2
75th Percentile	10
High	40
Low	0

RUC Recommendation: 16 RVUs based on the survey median.

The Committee arrived at this conclusion by accepting 12.74 RVUs for the basic vaginal hysterectomy and adding to that half of the work value for 57268, repair of enterocele, CPT 57268 (6.47 RVUs x 50% or 3.23 RVUs). The total of 15.97 RVUs was so close to the survey median that the Committee concurred.

CPT Code and Descriptor:

589XX - Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(ies) (laparoscopic-assisted vaginal hysterectomy)

Survey Sample: 24

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	17 (71%)	14 (58%)
Median	18	18
25th Percentile	14	14
75th Percentile	19	19
Low	12.74	12.74
High	25	25

Key Reference Services Used (ranked by number of mentions)

58260 (9)* vaginal hysterectomy (12.74 RVUs)
58988 (5)* laparoscopy with removal of adnexal structures (5.89 RVUs)
58980 (3)* laparoscopy, diagnostic (4.25 RVUs)
58985 (3)* laparoscopy, with lysis of adhesion (4.61 RVUs)
58140 (2) 58150 (2) 58285 (2) 58200 (1) 58982 (1) 58986 (1)

Assumptions About Typical Patient (ranked by number of mentions)

(Lysis) adhesions (5) Middle-aged (30-55) (4)
Endometriosis (3) Menorrhagia (2)

Assumptions About Nature of Service (ranked by number of mentions)

Respondent Experience with Procedure (frequency within past year)

Median	5
25th Percentile	3
75th Percentile	15
High	56
Low	0

RUC Recommendation: 14.61 RVUs

The ACOG RUC Committee arrived at this recommendation by first using 12.74 RVUs for a basic vaginal hysterectomy. Then, to account for the laparoscopy work, the Committee averaged the work RVUs of the three reference laparoscopy codes (5 RVUs) reduced that work value by 25% since there is no additional post-op work. The adjusted RVU of 3.75 was then reduced by half using Medicare's rule for multiple procedures (1.87 RVUs). The recommended 14.61 RVUs combines 12.74 RVUs and 1.87 RVUs.

SUMMARY OF SURVEY RESULTS

CPT Code and Descriptor:

589XX - Hysteroscopy, surgical; with sampling, (biopsy) of endometrium and/or polypectomy with or without D&C

Survey Sample: 24

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	16 (67%)	14 (58%)
Median	3	3
25th Percentile	2.56	2.6
75th Percentile	3	3.6
Low	2.25	2.52
High	5	5

Key Reference Services Used (ranked by number of mentions)

58990 (11)* hysteroscopy, diagnostic (2.52 RVUs)
58992 (5)* hysteroscopy, with lysis of intrauterine adhesions or resection of intrauterine septum (any method) (3.39 RVUs)
58120 (4) 58994 (3) 58996 (1)

Assumptions About Typical Patient (ranked by number of mentions)

Abnormal uterine bleeding (8)
40s (4)
Not responding to chemical therapy (2)

Assumptions About Nature of Service (ranked by number of mentions)

Respondent Experience with Procedure (frequency within past year)

Median	10
25th Percentile	5
75th Percentile	17.5
High	100
Low	1

RUC Recommendation: 3.0 RVUs

3.0 RVUs. ACOG's RUC Committee believes the new code falls between the key reference services and the survey median of 3.00 is reasonable.

SUMMARY OF SURVEY RESULTS

CPT Code and Descriptor:

58992 - Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)

Survey Sample: 24

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	13 (54%)	5 (21%)
Median	4	4
25th Percentile	3.39	3.5
75th Percentile	4.5	4.5
Low	3	3
High	7	6

Key Reference Services Used (ranked by number of mentions)

58992 (8)* hysteroscopy with lysis of intrauterine adhesions or resection of intrauterine septum (any method) (3.39 RVUs)
58990 (6) 58994 (3) 58120 (2) 58996 (1)

Assumptions About Typical Patient (ranked by number of mentions)

Infertility (5)
Recurrent pregnancy loss (3)
Amenorrhea (2)

Assumptions About Nature of Service (ranked by number of mentions)

Median	1
25th Percentile	0
75th Percentile	2
High	30
Low	0

RUC Recommendation: 3.39 RVUs

The Committee believes the work for this code is the same as the work for the key reference service and therefore supports the survey (25th percentile).

CPT Code and Descriptor:

589XX - Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)

Survey Sample: 24

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	13 (54%)	3 (13%)
Median	4	4
25th Percentile	3.75	3.75
75th Percentile	4.5	7.5
Low	3	3.75
High	7.5	7.5

Key Reference Services Used (ranked by number of mentions)

58992 (8)* hysteroscopy with lysis of intrauterine adhesions or resection of intrauterine septum (any method) (3.39 RVUs)
58990 (4) 58994 (3) 58996 (2) 58120 (1) 58988 (1)

Assumptions About Typical Patient (ranked by number of mentions)

Recurrent pregnancy loss (6)
Infertility (5)

Assumptions About Nature of Service (ranked by number of mentions)

More difficult than previous 58992 (2)

Respondent Experience with Procedure (frequency within past year)

Median	0
25th Percentile	0
75th Percentile	1
High	25
Low	0

RUC Recommendation: 4.00 RVUs

The key reference service is less work than that of the new code since it does not include division of septum. The survey median thus is reasonable.

CPT Code and Descriptor:

589XX - Hysteroscopy, surgical; with removal of impacted foreign body

Survey Sample: 24

Distribution of Work Estimates

	All Respondents	Those Who Had Offered Service More than Once During Past Year
Response Number/Percent	13 (54%)	3 (13%)
Median	3.25	3
25th Percentile	3	3
75th Percentile	3.5	3.5
Low	2.6	3
High	7	3.5

Key Reference Services Used (ranked by number of mentions)

58990 (9)* hysteroscopy, diagnostic (2.52 RVUs)
58992 (5)* hysteroscopy with lysis of intrauterine adhesions or resection of intrauterine septum (any method) (3.39 RVUs)
58994 (2) 58120 (1) 58996 (1)

Assumptions About Typical Patient (ranked by number of mentions)

"Lost" or impacted IUD (10)

Assumptions About Nature of Service (ranked by number of mentions)

Respondent Experience with Procedure (frequency within past year)

Median	0
25th Percentile	0
75th Percentile	1
High	5
Low	0

RUC Recommendation: 3.25 RVUs

The Committee believes the new code falls between the two key reference services and therefore the survey median is reasonable.

ATTACHMENT 3

AMERICAN SOCIETY OF
PLASTIC AND RECONSTRUCTIVE
SURGEONS INC

EXECUTIVE OFFICE
444 EAST ALGONQUIN ROAD
ARLINGTON HEIGHTS IL 60005
708 228-9900
FAX (708) 228-9131

ASPRS PROCESS FOR ESTIMATING WORK RVUs FOR NEW OR REVISED CPT CODES

These recommendations are based on the results of a survey of 88 ASPRS members identified from the following groups:

ASPRS Board of Directors
ASPRS Socioeconomic Commission
- . AMA Liaison Committee
- . CPT Committee
- . Government Relations Committee
- . Guidelines Committee
- . Risk Management Committee
- . Socioeconomic Committee
  - - Alternate Health Care Subcommittee
  - - Health Policy Analysis Subcommittee

ASMS (Amer. Soc. Maxillofacial Surgeons) Socioeconomic Committee

The AMA's standardized survey materials and a customized cover letter were sent to survey participants on June 10, with a response requested by June 16. On June 16, sixteen responses had been received (18 percent response rate).

ASPRS staff tabulated the responses and calculated medians and percentile rankings. Results from the codes that were reviewed are attached. Comments on influential factors that may have affected the ratings will be presented verbally.

ASPRS' Health Policy Analysis Subcommittee reviewed the results of the survey to determine whether the estimate from the survey should be modified or retained. Objective explanations were requested for each modification. This subcommittee has been closely involved in developing the new Medicare Fee Schedule as it relates to plastic surgery, and is very familiar with the process used for developing relative work values.

Tracking Number:	140
CPT Code:	304XX•
CPT Descriptor:	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
Type of Revision:	A new code added for cleft lip rhinoplasty
Key Reference Services:	14060, 19318, 42415
Median:	1000
25th Percentile:	900
75th Percentile:	1300
Low:	600
High:	2000
Recommended RVU (x100):	1000

Tracking Number:	313
CPT Code:	213XX•
CPT Descriptor:	Open treatment of nasal septal fracture, with or without stabilization
Type of Revision:	New code for open treatment of nasal septal fracture
Key Reference Services:	19318, 14060, 21453, 21493
Median:	500
25th Percentile:	380
75th Percentile:	750
Low:	150
High:	1150
Recommended RVU (x100):	600

Tracking Number:	320
CPT Code:	213XX•
CPT Descriptor:	Open treatment of nasomaxillary complex fracture (LeFort II type): with wiring and/or local fixation; with bone grafting (includes obtaining graft)
Type of Revision:	New code for open treatment of nasomaxillary fracture with bone grafting
Key Reference Services:	15946
Median:	2000
25th Percentile:	1250
75th Percentile:	2250
Low:	1000
High:	3000
Recommended RVU (x100):	2000

Tracking Number:	335
CPT Code:	214XX•
CPT Descriptor:	Open treatment of craniofacial separation (LeFort III type); with wiring and/or ~~local~~ internal fixation; complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)
Type of Revision:	New code for open treatment of craniofacial separation
Key Reference Services:	15946
Median:	2200
25th Percentile:	1800
75th Percentile:	2500
Low:	1798
High:	3500
Recommended RVU (x100):	2400

Tracking Number:	341
CPT Code:	21453
CPT Descriptor:	Closed treatment of mandibular fracture ~~with manipulation~~ with interdental fixation
Type of Revision:	Revised to describe closed treatment of mandibular fracture with interdental fixation
Key Reference Services:	13152, 15937
Median:	637
25th Percentile:	400
75th Percentile:	940
Low:	315
High:	1200
Recommended RVU (x100):	635

Excerpts from: AMERICAN ACADEMY OF OTOLARYNGOLOGY
HEAD & NECK SURGERY

Tracking Number: 322
CPT Code: 213XX
CPT Descriptor: Open treatment of depressed zygomatic arch fracture (eg, Gilles approach)
Type of Revision: New code for open treatment of depressed zygomatic arch fracture.
Global Period: 10 days

What is involved in this procedure? Again, the patient has incurred maxillofacial trauma. A typical patient will be initially examined in the emergency room or perhaps in the surgeon's office. The patient will have a cosmetic deformity due to the loss of projection of the zygomatic arch along with trismus. Plain radiographs will cooroborate the diagnosis.

The procedure may be performed in the physician's office, outpatient surgery center or hospital setting under local or general anesthesia as an inpatient or ambulatory patient. The area is infiltrated with local anesthetic and the scalp prepared for an incision. Through the incision, an instrument is used to elevate the depressed zygomatic fracture. In this approach, there is a danger of damage to the frontal branch of the facial nerve. If the fracture is not stable upon reduction, then external or internal fixation may be required.

The individual may be released the same day of surgery or requires a single hospital day. The patient will be examined in the surgeon's office in one week for suture removal and examination of 10 to 15 minutes duration. Another examination in 4 to 6 weeks precedes discharge.

Key comparisons:

Code 21325: Open treatment of nasal fracture; uncomplicated. Work RVU's = 371.
Comment: Less work than proposed code.

Code Ref 4, 21330: Open treatment of nasal fracture; complicated with internal and/or external fixation. Work RVU's = 531.

Comment: Similar scope of treatment. Both areas are important cosmetically. No fixation is involved in Gilles approach. Less finesse required in treatment of depressed zygomatic arch fracture.

ATTACHMENT 5a

AMERICAN ACADEMY OF OPHTHALMOLOGY

BRUCE E. SPIVEY, M.D.
Executive Vice President

DAVID J. NOONAN
Deputy Executive Vice President

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GOVERNMENTAL RELATIONS

CYNTHIA ROOT MORAN
Director

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Washington, D.C. 20005-3570
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Memorandum

Date: June 17, 1992

To: Mark Segal, Ph.D.

From: Stephen Kamenetzky, MD

Re: American Academy of Ophthalmology
Report to the RVS Update Committee
on Recommended Work Values for:
#0011 - Repositioning IOL
#227 - Lacrimal Punctum
#327 - Orbit fracture w/graft

Summary.

The American Academy of Ophthalmology has developed the following recommended work values, based on the methodology for establishing physician work values for new CPT codes, as outlined by the AMA RVS Update Committee.

Tracking Number	CPT Code	CPT Descriptor	Recomm. Work RVU
0011	658xx	Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)	8.15
227	687xx	Closure of lacrimal punctum; by plug, each punctum	1.38
327	214xx	Open treatment of fracture of orbit, except "blowout"; with bone grafting (includes obtaining graft)	15.00

Reference list.

The recommended work values were developed by comparing the new codes to procedures on the reference lists for ophthalmology and plastic surgery. Ophthalmology's reference list was expanded to include additional visit services, at the request of the RUC. Reference lists developed by other specialties were not provided; and, no cross-specialty references were identified.

Methodology.

A survey of the above three codes was conducted, using materials provided by the AMA RUC staff. Ophthalmologists specializing in the anterior segment, ophthalmic plastic surgeons, and general ophthalmologists participated in the survey. Participants were

asked to provide: (1) an estimate of the physician work RVUs for each code; (2) the most appropriate reference procedures from either the ophthalmology or plastic surgery list; (3) a description of the typical patients and relevant comments; and (4) how many times they had performed the service.

Responses were tallied, and the median, 25th percentile and 75th percentile were determined for each new code. Selected reference procedures, and comments on the typical patients and the scope of each procedure were summarized. Each of the respondants who provided work values had performed the procedure they rated.

The Academy's Federal Economic Policy Committee serves as the standing RUC review committee. The Committee held a conference call to review and validate the results of the survey. The Committee members agreed that the values developed through the survey represented a rational, and appropriate rank-order placement within ophthalmology's scale for the new codes, in comparison to existing ophthalmic services of a similar nature and value.

Discussion of Specific Survey Results.

#0011: Repositioning of Intraocular Lens Prosthesis, Requiring an Incision (separate procedure)

The typical patient has an intraocular lens implant which is not functioning properly, has become dislocated, and/or is jeopardizing the cornea, pupil function or ocular pressure. The surgeon performs a microscopic evaluation of the IOL's relationship to structures and functions of the eye, a local or general anesthetic is administered, and the surgeon re-enters a previously operated eye with possible scarring, inflammation, or increased intraocular pressure. There is uncertainty regarding whether the lens will become further dislocated during the procedure, and suturing may be necessary. The patients are followed during the 90-day post-operative period to re-evaluate the relation of the IOL to the internal structures and functions of the eye.

The respondants work value ratings for this procedure were arrayed from highest to lowest, resulting in the following:

Median:	8.15 Work RVUs
25th Percentile:	8.33
75th Percentile:	8.00

The extremely close clustering of these responses indicate that the median is a good representation of the value of this service among ophthalmologists.

The most commonly cited reference procedures selected by respondants were:

CPT Code	Work RVU	CPT Descriptor
65235	7.20	Removal of ocular foreign body; intraocular; from anterior chamber.
66895	8.32	Insertion of IOL prosthesis (secondary implant), not associated with concurrent cataract removal.

The physician work for this new code, as reflected in the median value of 8.15 work RVUs, falls between these two reference procedures. The Federal Economic Policy Committee reviewed the median value and the selection of reference codes, and during a conference call, agreed that the reference services were appropriate, and that the median value appeared to fall within the appropriate rank-order of related ophthalmic services.

A previous study, conducted on a different sample of ophthalmologists, produced a median work RVU of 7.80. This value is within 4% of the 8.15 median work RVU produced by the most recent survey, indicating that the methodology appears sound, and the recommended work RVU is valid.

In conclusion, based on the survey and committee validation process, the Academy recommends that the RUC adopt a work value of 8.15 for tracking #0011.

<u>#227: Closure of Lacrimal Punctum; By Plug, each.</u>

The value of this procedure will be discussed in terms of the physician's work only; the cost of the implant is not included in the recommended value. In addition, the values relate to the work per individual punctum. If more than one implant is inserted concurrently, the subsequent value is reduced by coding with the appropriate multiple surgery modifier.

The typical patient has severe dry eye syndrome due to decreased tear production, which cannot be adequately managed with topical agents, resulting in irritation and defects which could jeopardize the cornea. Following an evaluation of the lacrimal system, and the effects of the topical agents, a decision to insert the plugs would be made. The procedure requires a nasolacrimal tray and special set-up. The patient receives a topical anesthetic, the punctum is dilated, and the implant is placed using microscopy. Post-operative follow-up includes the evaluation of function, and the possible readjustment, repositioning or removal of the implant.

The respondants work value ratings for this procedure were arrayed from highest to lowest, resulting in the following:

Median:	1.38 Work RVUs
25th Percentile:	2.00
75th Percentile:	0.70

Many respondants commented that the reference list did not provide services that they could easily match to the new code, which could explain the spread in values. Frequent selections included:

CPT Code	Work RVU	CPT Descriptor
17000	0.68	Destruction by any method, including laser, with or without surgical curettement, all benign facial lesions or premalignant lesions in any location.
99203	1.14	Office or other outpatient visit for the evaluation and management of a new patient, which requires the following: a detailed history, a detailed examination; and medical decisionmaking of low complexity.

The median work RVU is higher than these reference procedures. The Federal Economic Policy Committee agreed that the median value of 1.38 appeared to be appropriately ranked, when compared to similar ophthalmic procedures as follows, that were not available on the reference list for the respondants consideration. These were not added to the reference list and respondants were encouraged to stay with the provided references to prevent any bias of selection.

CPT Code	Work RVU	CPT Descriptor
68760	1.77	Closure of lacrimal punctum (eg, thermocauterization, ligation, or laser photocoagulation)
68800	1.16	Dilation of lacrimal punctum, with or without irrigation

CPT 68800 represents dilation of the punctum, which is considered an integral part of the implant procedure. Therefore, the new code would entail at least 19 percent more work in the insertion of the implant following dilation, as reflected in the difference between the work RVU for 68800 of 1.16 and the median of 1.38 for the new code. In contrast, CPT 68760 represents the surgical

closure of the punctum, a more involved and permanent procedure, usually performed on the same patient, if the condition worsens. The work RVU for 68760 of 1.77 is 22 percent greater than the median of 1.38 work RVUs for the new code. The committee agreed that the median value of 1.38 work RVUs, situated between the values for CPT 68760 and 68800 represents a rational and appropriate rank-order value among ophthalmic services for the new code.

In conclusion, based on the survey and committee validation process, the Academy recommends that the RUC adopt a work value of 1.38 for tracking #227.

#327: Open treatment of fracture of orbit, except "blowout"; with bone grafting (includes obtaining graft).

The typical patient has a fracture of the orbit rim or wall, from severe trauma, such as an automobile accident, which may be associated with head trauma, multiple facial lacerations and multiple orbital and facial fractures, and possible damage to the globe. The surgery is performed under general anesthesia, and may be part of a team with neurosurgery, etc. The bone graft is harvested from one site, then a surgical entry to the orbit is performed, the bone is placed so as not to affect motility or vision of the eye, and may require internal fixation. The patient is usually high risk with associated neurosurgery, blood transfusions, and treatment for infection required. The ophthalmologist provides an extensive pre-operative work-up, and long term follow-up care.

The respondants work value ratings for this procedure were arrayed from highest to lowest, resulting in the following:

Median:	15.00 Work RVUs
25th Percentile	18.00
75th Percentile	11.80

The median is within about 16 percent of the 25th and 75th percentiles. This variation is probably a result of the available reference procedures, and may also be a reflection of the variability of the trauma presentation.

Survey respondants indicated that the work value was appropriately situated between the following reference procedures:

CPT Code	Work Value	CPT Descriptor
21433	11.68	Open treatment craniofacial separation, complicated
21267	18.62	Orbital repositioning, periorbital osteotomes, unilateral with bone grafts; extracranial approach

The physician work involved in this new code, as reflected in the median value of 15.00 work RVUs, falls between these two reference procedures. The committee reviewed the median value and the selection of reference codes, and during a conference call, agreed that the reference services were appropriate, and that the median value appeared to fall within the appropriate rank-order of related ophthalmic services. The committee was concerned that the value also fall within the appropriate rank-order for the new series of plastic surgery codes of which the new code is a part. The results of the plastic surgeons survey were not available for review at the time of the conference call. However, staff indicated that the 15.00 work RVU appeared to fall within the range of values provided by plastic surgeons on their untallied survey forms.

The committee also noted that other orbit surgical procedures (which did not appear on the reference list), such as 67420, orbitotomy with bone flap; and 67445, orbitotomy with removal of bone for decompression, both have a physician work RVU of 14.08, about 7 percent lower than the median value of 15.00 for the new code, which includes the additional work and second surgical site to obtain the graft.

In conclusion, based on the survey and committee validation process, the Academy recommends that the RUC adopt a work value of 15.00 for tracking #327.

* * *

Thank you for this opportunity to present the findings of the American Academy of Ophthalmology's survey to establish physician work RVUs that fall within the appropriate rank order of ophthalmic services, for the new CPT codes represented by tracking numbers 0011, 227, and 327.

Please feel free to contact me at 314-367-0071 or Academy staff: Mr. David Noonan, at 415-561-8500, or Ms. Stephanie Mensh, at 202-737-6662.

ATTACHMENT 5b

AMERICAN ACADEMY OF OPHTHALMOLOGY

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MEMORANDUM

Date: May 20, 1992

To: Mark Segal, Ph.D.

From: Steven Kamenetzky, MD

Re: Physician Work Values for New Ophthalmic Codes

The following outlines the process utilized in and the outcome of the American Academy of Ophthalmology's efforts to assign physician work relative value units to new ophthalmic CPT codes expected to be added in 1993:

(1) Ref. 0010: Severing Adhesions of anterior segment, laser technique (separate procedure)

Recommended Physician RVU: 355

The Academy's standing Federal Economic Policy Committee served as our RVS Committee. The Committee is composed of nine ophthalmologists and provides a broad spectrum of practice styles, geographic areas, and general and subspecialty disciplines. The full Committee reviewed and recommended additions and deletions to the initial list of reference services developed by the AMA. Two members reviewed the subsequent list and recommended a "short" list of those reference procedures for use in studying the new codes, as requested by the AMA.

Copies of the pertinent AMA instructions, reference list, and survey form were distributed to approximately 55 ophthalmologists attending a national conference sponsored by the Academy. These ophthalmologists represented most states and ophthalmic subspecialties.

During the meeting, prior to returning the forms, a brief discussion explaining the new codes and the purpose of the survey was led by the Academy's Relative Value Update Committee representative and CPT Editorial Advisory Panel representative. There were 16 completed forms returned, equalling a response rate of 29 percent.

The values were arrayed to determine the median, 75th percentile and 25th percentile for each of the codes, as follows:

(1) Ref. 0010: Severing Adhesions of anterior segment, laser technique (separate procedure)

Median:	375
75th Perc.	397
25th Perc.	350

Typical patient: Usually a post-operative patient with vitreous to cataract wound. After a period of time, the procedure becomes necessary if the condition does not resolve itself. It is a relatively infrequent condition.

The Federal Economic Policy Committee, serving as the Academy's RVS Committee, reviewed these values, and after some discussion, made the following recommendations:

(1) Ref. 0010: Severing Adhesions of anterior segment, laser technique (separate procedure)

The median value of 375 appeared a little high. The new procedure is considered to be slightly less than a similar procedure, CPT 67031, based on the definition of physician work. Since 67031 is valued at 361, the FEP/RVS Committee recommended valuing the new procedure at 355 physician work units.

The Committee was unable to crosswalk these codes to previous codes. Both procedures are relatively infrequently performed, and were probably billed under an "unspecified" service code or inconsistently under other codes. The new codes were requested because there was not an existing code that provided an adequate description.

RUC Action on Orthopedic Trauma Revisions

The RUC accepted the results of the orthopedic trauma relative value study. The results appear reasonable and within the range of acceptability.

This action is qualified, however, by the following observations:

(1) The methods used are different and thus may not be directly comparable to other RUC recommendations being transmitted.

(2) Timing did not allow a complete evaluation by the RUC of the methods.

(3) As with other methods, results of the study may be influenced by key factors including the selection of baseline services, but analysis of this potential was not possible at this time, given the study design.

(4) There needs to be prompt study of this method when applied for other physician services, particularly non-surgical services.

The RUC is continuing to review this proposal and will provide additional comments as warranted.

American Academy of Orthopaedic Surgeons
222 South Prospect Avenue, Park Ridge, Illinois 60068-4058
Phone 708/823-7186 • 800/346-AAOS • Fax 708/823-8125

June 15, 1992

REC'D JUN 1 7 1992

Mark J. Segal, Ph.D.
Director
Department of Health Care Financing and Organization
American Medical Association
515 North State Street
Chicago, Illinois 60610

Dear Dr. Segal:

The American Academy of Orthopaedic Surgeons (AAOS) is pleased to present relative work value recommendations for 65 new and revised orthopaedic trauma codes, and a new code for elbow capsulotomy/capsulectomy.

I. INTRODUCTION

In reviewing the current Medicare fee schedule, the AAOS found numerous inconsistencies between the relative work values assigned to orthopaedic procedures and clinical reality. As a result, the AAOS has been working with Abt Associates to re-study completely the work involved in the approximately 1600 procedures performed by orthopaedic surgeons. This re-study (hereafter referred to as the Abt Re-study) has involved numerous consensus panels of orthopaedic surgeons representing the major sub-specialties of orthopaedics (trauma, adult reconstructive, spine, upper extremity, foot, pediatric orthopaedics and sports medicine). There also have been several cross-sub-specialty review panels. Each of these consensus panels has included general orthopaedists as well as sub-specialists. In addition, a phone survey of over 100 orthopaedists was conducted, the data from which form the basis for aligning the different sub-specialties' relative work values to each other. Magnitude estimation techniques were used to measure all pre- and post-operative work, as well as intra-operative (skin-to-skin) work directly. The resulting scale provides relative work values that are, in some cases, quite different from those in the current Medicare fee schedule. As a consequence, it has been difficult to establish relative work values for the new and revised orthopaedic codes that are both internally logical, from a clinical standpoint, and consistent with the current fee schedule.

II. THE NEW AND REVISED ORTHOPAEDIC CODES

The orthopaedic trauma sections of the CPT code will be substantially modified in 1993. Definitions for nearly all of the approximately 350 orthopaedic trauma codes have been modified, at least slightly. About 80 codes have been deleted, while 49 new codes have been added. In addition, a new code for elbow capsulotomy/capsulectomy has been established.

The AAOS Work Valuation Panel involved in the Relative Value Scale (RVS) Update Process determined that, in addition to the new codes, relative work values needed to be assigned to 16 of the revised trauma codes because their descriptors had changed enough to warrant re-valuation. In establishing relative work values for the 66 new and revised codes, the AAOS followed the AMA's suggested protocol as described below. In addition, however, the new relative work values were derived to be as consistent as possible with the valuation of the universe of trauma codes that is being undertaken as part of the Abt Re-study of all of orthopaedics.

III. WORK VALUATION PROCESS

The process of assigning relative work values to the 66 new and revised codes was thorough and deliberative involving the efforts of two separate panels of orthopaedists. Efforts were made to derive work values that reflected a consensus of opinion across all orthopaedic sub-specialties. As a result, the values assigned to the new and revised codes accurately reflect the work involved in each of them, and serve the AAOS' broader goal of achieving an equitable assessment of the work involved in all of orthopaedics.

The AAOS selected a representative group of actively practicing orthopaedic surgeons to serve on the Work Valuation Panel. The physicians who participated are as follows:

Alan Morris	Sports Medicine (RVS Update Adv. Comm.)	St. Louis, MO
Stephen Albanese	Pediatric Orthopaedics	Syracuse, NY
Bruce Browner	Orthopaedic Trauma	Houston, TX
M. Bradford Henley	Orthopaedic Trauma	Seattle, WA
Michael Major	Spine & General Orthopaedics	Milwaukee, WI
Andrew Palmer	Hand (Abt Re-study Dir.)	Syracuse, NY
Mel Post	Shoulder	Chicago, IL
Duret Smith	Hand	Cleveland, OH
Peter Trafton	Orthopaedic Trauma	Providence, RI
Dwight Webster	General Orthopaedics	Syracuse, NY

A. Step One

The AAOS, working with Abt Associates, prepared a survey instrument based on the AMA's model (see Appendix 1 for instrument). This survey instrument was mailed to the Work Valuation Panel before its meeting. The survey instrument included 15 of the new and revised trauma codes and the new elbow capsulotomy/capsulectomy code. The 15 new and revised trauma codes were selected because they broadly represent the types of coding changes made in the entire universe of trauma codes.

A set of 7 reference services was selected to assist in evaluating these 15 new and revised trauma codes, and a set of 3 reference services was chosen to assist in evaluating the elbow capsulotomy/capsulectomy code. The reference services were selected based upon the following criteria: 1) reference services were selected that seemed to be relatively comparable to the universe of new and revised codes, 2) reference services were selected with relative work values that seemed internally consistent, in Medicare fee schedule terms, relative to each other based on preliminary findings of the Abt Re-study of all of orthopaedic surgery, and 3) reference services were chosen to reflect varying levels of work required.

At the Work Valuation Panel meeting, medians of the total work estimates collected from the survey instrument were provided to the panelists to initiate discussion. To facilitate comparison, these medians were rescaled to reflect a common orthopaedic trauma procedure, repair of an intertrochanteric hip fracture (CPT 27244).

B. Step Two

To assess the clinical face validity of the medians derived from the pre-meeting survey, the panel initiated a discussion of each of the 16 surveyed codes in terms of the work required in the different pre-, intra and post-operative time periods. This approach involved an assessment of the work involved in 7 distinct time periods: pre-operative, pre-incision, skin-to-skin, post-incision, immediate post-operative, same day/later post-operative, and post-discharge/office. (See Appendix 2 for period definitions.) Prior to assessing the work involved in each period, the panel discussed the definition of work to ensure consistent interpretation of what is and is not included in the period. Total work for each procedure was calculated as the sum of work in the seven component periods.

This methodology, which is consistent with the RVS update methodology, was used because it has been Abt Associates' experience that surgeons often have difficulty estimating the relative work values of procedures if they are only asked about total work; surgeons tend to focus primarily on skin-to-skin work and neglect pre and post-operative activities (e.g., the pre-incision and post-incision periods in the operating room) for which the relation to skin-to-skin work varies across procedures. Therefore, relative work values are often overly influenced by skin-to-skin activities unless explicit consideration is given to pre- and post-operative activities. In addition, this methodology is consistent with the approach that Abt Associates has used in developing work values for all of orthopaedic surgery.

C. Step Three

After using a consensus process to derive total work values for the 16 survey codes based on the separate assessment of each of the different work periods, the Work Valuation Panel compared its findings to the medians derived from the pre-meeting survey. For purposes of this comparison, the work values from the pre-meeting survey and the work values from the separate assessment of work periods were placed on a common scale relative to an intertrochanteric hip fracture, CPT 27244; with the hip fracture set equal to 1. There was unanimous agreement that the values developed at the meeting better reflected the relative work for each of the 15 trauma procedures (plus the elbow procedure) than the medians derived from the pre-meeting survey. The panel, through further consensus-building discussion, then extrapolated total work values for the remaining new and revised trauma codes from the work values for these 15 trauma codes.

The Work Valuation Panel also spent considerable time reviewing the universe of trauma codes for consistency in light of the new and revised codes' relative work values. The panel re-examined this universe of codes, including the new and revised codes, both in CPT order and in descending work value order. The result provided clinically consistent rankings of the new and revised codes in the context of the broader Abt Re-study of all of orthopaedics.

D. Step Four

Because the RVS Update Process is parallel to and running concurrently with the Abt Re-study of all of orthopaedics, the re-study's Technical Consulting Panel--approximately 30 orthopaedic surgeons from all sub-specialties--reviewed the relative work values for the new and revised codes as part of its overall review of work values for all of orthopaedics.

IV. UNRESOLVED ISSUES RELATING TO PROCESS

While the Work Valuation Panel participated in and met the guidelines of the RVS Update Process, it was the panel's belief that the success of that process was inherently limited by incongruities in the relative work values contained in the existing Medicare fee schedule. The RVS Update Process relies on the assumption that the current fee schedule properly aligns the universe of existing codes according to their relative work. Since the AAOS strongly believes that the Medicare fee schedule's relative valuation of orthopaedic procedures is flawed, the selection of one or more reference services for assigning work values to new and revised codes results in those codes being misaligned relative to other codes in the fee schedule. This problem is particularly acute when new and revised codes, such as the orthopaedic trauma codes, span a broad range of services.

The work valuation process described above achieved clinically appropriate relative rankings of all 65 new and revised orthopaedic trauma codes. The resulting work values for these codes have clinical face validity in relation to each other and in relation to the work values for currently existing trauma codes, as derived from the Abt Re-study. However, when the work values for the 65 new and revised trauma codes are compared to the current fee schedule's work values for the existing trauma codes, these work values are inconsistent with each other due to the fee schedule's incongruities. In particular, discrepancies sometimes arise between codes describing very similar treatments. Work values that were derived relative to one reference service procedure and have a good relationship with that procedure may look improperly valued when compared to other services, whether or not they were related to the reference service. Appendix 3 includes examples of incongruities that result depending upon the choice of reference services.

As an alternative, the Work Valuation Panel took the following additional step. Each new and revised code was assigned to a reference service based on the new and revised code's clinical similarity to the reference service. In some cases, entire "families" of clinically similar codes are assigned the same reference service. The recommendations presented below rank each new and revised code relative to its designated reference service using the results of the valuation process described above, which provided relative work values for the *universe* of orthopaedic trauma codes. These rankings provide ratios that define the position of each new and revised code relative to its reference service. While these ratios can be translated into current fee schedule units, the AAOS believes that it is more appropriate to focus on the ratios themselves, rather than the absolute Medicare work value numbers.

Since considerable effort is currently being expended by HCFA and others to revise and refine the existing Medicare scale of work, the values currently assigned to the selected reference services may change. In cases where this occurs, it will be important to make similar changes to related new and revised codes. Therefore, the relative relation (ratio) of a new and revised code to its reference service is more important than the absolute work value numbers assigned within the confines of the current fee schedule.

IV. SIMULATIONS OF VALUES

A. New and Revised Trauma Codes

Table 1 presents the AAOS' recommendations for the 65 new and revised orthopaedic trauma codes as well as the new elbow capsulotomy/capsulectomy code. AMA tracking code numbers are shown as well as the likely CPT code to be assigned to the procedures. Descriptions of each code also are included. The words "New" and "RV" next to the CPT code indicate whether the code is being valued because it is new to CPT or whether its description was revised in a way that will alter its work. Reference services and their current Medicare fee schedule values (times 100) are shown; justification for their selection will be provided at the June RUC meeting. The column entitled "Ratio to Ref Code" presents the AAOS' recommendation regarding how each new and revised code should be valued *relative to* its designated reference service. The "Implied Work" column provides the work value (times 100) that is derived by applying this ratio to the reference service's work value as assigned under the current fee schedule.

In some cases, two reference services produced very similar ratios and work values. In these cases, the table shows the CPT code for both reference services and their respective Medicare work values. The resulting "Implied Work" value is an average of the results using both reference services. An asterisk next to certain reference services indicates that the code is being valued relative to a revised code's original fee schedule work value because the original code has been split into two (one new and one revised) codes. The next two paragraphs describe how this was accomplished.

In several cases, one code in the 1992 CPT has been divided into two codes that distinguish between two methods for treating the same condition. These codes are indicated on the table with boxes around them (e.g. 24515 and 24516 on page 1). In these cases, recommendations are calculated in such a way as to ensure that the same total work is assigned to the two codes as was assigned to the single original code.

This task is accomplished by projecting how the total volume of the single original code is expected to be distributed between the two new or revised codes, taking the work value ratio of one code to the other and solving algebraically for their values given the current fee schedule value assigned to the single old code. Thus, the two new codes work values are established so that their frequency-weighted average equals the work value of the original code as defined under the fee schedule while maintaining the relationship indicated by the Work Valuation Panel and the Abt Re-study of all of orthopaedics.

Codes have been grouped into clinically similar families to facilitate discussion at the RUC meeting. Where appropriate, all codes in a family are related to the same reference service; however, in several cases, it was more clinically appropriate to rely on distinct references for each code. Table 2 contains CPT codes and descriptors for the reference services used for all new and revised orthopaedic codes, including the new elbow capsulotomy/capsulectomy code.

The impact of accepting the "Implied Work" values for the new and revised trauma codes is modest; aggregate work assigned to all orthopaedic trauma codes changes by .41 percent. This calculation is based on 1990 BMAD I total allowed frequencies that have been adjusted to account for deleted, revised and new codes. This required judgements about expected volume changes or shifts. Volume of service estimates were made based upon the crosswalks indicated in the original proposal for trauma coding changes submitted to the CPT Editorial Panel, the CPT Editorial Panel's April 1992 meeting notes, and from discussions with the orthopaedic surgeons on the Work Valuation Panel established to develop these recommendations. At the June RUC meeting, a sensitivity analysis of these volume shift assumptions will be presented.

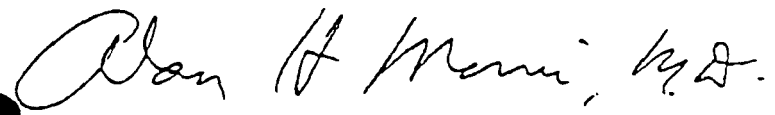
B. Elbow Capsulotomy/Capsulectomy Code

The Work Valuation Panel ranked the new elbow code as 1.05 of the benchmark service, the intertrochanteric hip fracture repair. In fee schedule terms this would value this new code at 15.99 (15.23 x 1.05) or 1599 on the scale that is multiplied by 100. In comparing this work value to the fee schedule work values of similar elbow and wrist services, it is evident that this valuation is too high. Moreover, valuation of the new code in fee schedule terms is highly dependant on the reference service chosen, as is the case with the orthopaedic trauma codes. Therefore, the panel chose the code deemed to be most clinically similar, the elbow arthrotomy for synovectomy (CPT 24102). On the basis of the work values derived from the Work Valuation Panel and the Abt Re-study, the ratio of the new elbow capsulotomy/capsulectomy code to the elbow arthrotomy code should be 1.30. Since the elbow arthrotomy code is currently valued at 797, a recommended value of 1033 in current fee schedule terms is implied for the new elbow code.

The budget implications resulting from this valuation of the new elbow capsulotomy/capsulectomy code should be trivial. It is infrequently performed (fewer than 10 times annually). Moreover, it is likely to be currently coded either as 24102 with a "22" modifier leading to additional payment or as 24360 (fascial arthroplasty of the elbow) with a "52" modifier that reduces payment. Since our proposed value falls between these two codes, the payment implications should be inconsequential.

Thank you for the opportunity to provide these relative work value recommendations. We look forward to the RUC's June deliberations.

Sincerely,



Alan H. Morris, M.D.
Member, AMA/Specialty Society RVS Update Advisory Committee

APPENDIX 1

AMA/SPECIALTY SOCIETY RVS UPDATING PROCESS: SURVEY INSTRUMENT

April 27, 1992

Conducted by:
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Sponsored by the American Academy of Orthopaedic Surgeons

April 27, 1992

AMA/SPECIALTY SOCIETY RVS UPDATING PROCESS: SURVEY INSTRUMENT FOR ORTHOPAEDIC SURGERY SPONSORED BY AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS (AAOS)

INTRODUCTION

The purpose of this survey is for you to rate the relative amount of physician work associated with one or more new or revised CPT codes. These codes are listed in the next section.

You have been selected to complete this survey and to consider its results as part of a committee organized by the AAOS which is participating in the AMA/Specialty Society RVS Updating Process. The committee will develop a recommendation on estimates of physician work for these services. This recommendation will be reviewed by the AMA/Specialty Society RVS Update Committee (RUC) which in turn will make a recommendation to the Health Care Financing Administration (HCFA). HCFA will consider this recommendation as it updates the new Medicare Payment Schedule (also called the Medicare Fee Schedule) for 1993.

You will use magnitude estimation. In this method, the work of selected services is used as a series of reference points for you to evaluate the work of each new or revised code under review. These reference services are from the new Medicare Payment Schedule and are listed in Table 1. Physician work includes the time it takes to perform the service as well as the three dimensions of the intensity of that time -- technical skill and physical effort, mental effort and judgement, and stress associated with your concern about iatrogenic risk.

First, you will provide estimates of the physician work associated with new or revised CPT codes used by your specialty. Next, you will identify the typical patient to whom you provide the services identified with each code as well as any special assumptions that you made in rating the service. Finally, you will provide information on the frequency with which you provide the service associated with each code.

If possible, please fax pages 4, 5, 6, and 8 of your completed survey to David Sheehy at Abt Associates, (617) 349-2675, by Thursday, Noon Eastern Time. Otherwise, please bring your survey to the meeting in Chicago and leave it at the front desk for David Sheehy when you arrive.

If you have any questions, please contact David Sheehy at (617) 349-2457.

Estimating Total Work: We first ask you to estimate the total work for each service. Total work encompasses the actual period spent performing the service as well as related work before and after the service. Please refer to Table 2 for a detailed description of each of the components of total work. Although you are only being asked about total work, please consider all of the applicable individual components of total work. In addition, consider the specific global service period associated with each new/revised code and each applicable reference service. These global periods are from the Medicare Payment Schedule. For new codes, the best estimate of the global period likely to be assigned by HCFA is provided.

Reference Services: To assist you in estimating work, we have selected a number of reference services provided by physicians in your specialty (Table 1). These include services that are clinically similar to those that we will ask you to rate as well as other commonly performed services in your specialty that cover a broad range of physician work. These latter services were chosen in cooperation with the AAOS. They are services from the Medicare Payment Schedule that can be used as reference services for this project because they are sufficiently accurate and stable, at least within broad categories of services (e.g., major surgery). Inclusion in this list does not mean that your specialty society may not also be pursuing refinement of these values with HCFA.

Rating Services: If the service involves twice as much work as a particular reference service, assign it a value equal to twice the work of that service. If you think that the service involves half as much work as the reference service, assign it a value equal to half the work of that service, and so on. In estimating the physician work associated with a service, please consider the time it takes to perform the service as well as the three dimensions of the intensity of that time -- technical skill and physical effort, mental effort and judgement, and stress associated with your concern about iatrogenic risk.

In all cases, please respond in terms of your average patient. In general (using the code in question) this should be the typical patient that you would see. At the same time, in formulating your estimates, please consider the extent to which your patients for which this code is used require either more or less work than your typical patient. Please do not allow your answers to be unduly influenced by unusual or atypical patients.

Please rate the work for the services listed below using the reference services and their work values in Table 1 as a guide. We anticipate that the most important comparisons will be to clinically similar services where many of the components of the services (e.g., follow-up care) will be the same or similar. Do not change the work values for any of the reference services. In some instances where you are asked to rate more than one code, you may find it easiest to first establish an overall rank order for the services listed below as well as the relationship of the work of each service to its adjacent services.

Experience with New or Revised Codes: You may not have recent experience with any or all of the services to be rated. We do ask that you provide ratings for those services about which you have recent and direct professional knowledge and feel comfortable answering, whether or not you currently perform the service. For those services for which you do not provide an estimate, please enter the letters "NR."

Survey Instructions:

1) *Given the total work values for the selected services for your specialty are shown in Table 1, what number would you assign to the total work for each of the services listed below? Again, please consider the detailed definition of the components of total work on Table 2 as well as the global periods in Table 1 and for each service below. Please also indicate, in priority order, those services from Table 1 that were important reference services for each service below (Use the number in column #1).*

2) *Next, please provide a brief description of the typical patient that you would expect to treat using the code and/or the nature of the services that you would expect to provide. Please also identify any special assumptions (e.g., associated procedures used) that you made in rating the code.*

3) *Finally, please indicate the number of times that you provided the service in the past twelve months.*

ORTHOPAEDIC SURGERY: American Academy of Orthopaedic Surgeons
New or Revised CPT Codes

Number	CPT Code	CPT Descriptor	Type of Revision	Work RVUs* (X 100)	Global Period**	Key Reference Services in Priority Order	Typical Patient and Nature and Extent of Services Provided -- Including any Special Assumptions You Made Rating the Service	About How Many Times in the Last 12 Months Have You Provided This Service?	If Zero, How Many Times Have you Provided the Service in Your Career?
1	24546	Open treatment of humeral supracondylar or transcondylar fracture with or without internal or external fixation; with intercondylar extension	new code		90				
2	25526	Open treatment of radial shaft fracture with internal and/or external fixation AND open treatment with or without internal or external fixation of distal radio-ulnar joint (Galeazzi fracture/dislocation)	new code		90				
3	27218	Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)	new code		90				
4	27228	Open treatment of acetabular fracture(s) involving anterior AND posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, OR single column or transverse fracture with associated acetabular wall fracture; with internal fixation	new code		90				
5	27244	Open treatment of basilar neck, intertrochanteric, pertrochanteric or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	modified description		90				
6	27506	Open treatment of femoral shaft fracture with or without external fixation with insertion of intramedullary implant, with or without cerclage and/or locking screws	modified description		90				
7	27509	Percutaneous skeletal fixation of supracondylar or transcondylar femoral fracture with or without intercondylar extension	new code		90				

Physician Name: _____

Number	[redacted] Code	CPT Descriptor	Type of Revision	Work RVUs* (X 100)	Gl[redacted] Pe[redacted]	Key Reference Services in Priority Order	Typical Patient and Nature and Extent of Services Provided – Including any Special Assumptions You Made Rating the Service	About How Many Ti[redacted] in the La[redacted] 12 Months Have You Provided This Service?	[redacted] How Many Times Have you Provided the Service in Your Career?
8	27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension with or without internal or external fixation	new code		90				
9	27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation	modified description		90				
10	27558	Open treatment of knee dislocation, with or without internal or external fixation; with augmentation/reconstruction, with or without primary ligamentous repair	new code		90				
11	27752	Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation with or without skeletal traction	modified description		90				
12	27759	Open treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	new code		90				
13	27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (i.e. pilon or tibial plafond); with internal or external fixation; of both tibia and fibula	new code		90				

Number	Code	CPT Descriptor	Type of Revision	Work RVUs* (X 100)	Global Period**	Key Reference Services in Priority Order	Typical Patient and Nature and Extent of Services Provided – Including any Special Assumptions You Made Rating the Service	About How Many Times in the Last 12 Months Have You Provided This Service?	If Zero, How Many Times Have you Provided the Service in Your Career?
14	27894	Decompression fasciotomy, leg; anterior and/or lateral AND posterior compartment(s); with debridement of nonviable muscle and/or nerve	new code		90				
15	29855	Arthroscopically-aided treatment of tibial fracture, proximal (plateau); unicondylar with or without internal or external fixation (includes arthroscopy)	new code		90				

*Note: Work RVUs from the Medicare Payment Schedule published in the Federal Register on November 25, 1991. They have been multiplied by 100 to assist the rating process.

**A service paid on a global basis includes visits and other services provided in addition to the basic procedure during a specified number of days before and after the procedure is provided. The *global period* identified above refers to the number of preprocedural and postprocedural days of care that are included in the payment for a global surgical package as determined by the Health Care Financing Administration for Medicare payment purposes. There are three categories of global services (090, 010, 000). In addition, there are two types of alpha global codes that may be used: XXX=Global concept does not apply to code; YYY=Global period to be set by Medicare carrier; ZZZ=Code part of another service and falls within global period for the other service. Refer to Table 2 for the services included in each type of global package.

A "separate procedure" is one that is commonly carried out as an integral part of a total service and thus not generally identified separately. In those instances, however, when such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure."

Physician Name: _____

Reference Services for Fracture Procedures

Number	CPT Code	CPT DESCRIPTOR	Work RVUs (x 100)	Global Period
1	29425	Application of short leg cast (below knee to toes); walking or ambulatory type	106	90
2	26055	Tendon sheath incision for trigger finger	269	90
3	23650	Closed treatment of shoulder dislocation, with manipulation; without anesthesia	342	90
4	23515	Open treatment of clavicular fracture, with or without internal or external skeletal fixation	739	90
5	27510	Closed treatment of femoral fracture, distal end, medial OR lateral condyle; with manipulation	863	90
6	27720	Repair of nonunion or malunion, tibia; without graft (e.g., compression technique)	1,154	90
7	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing ("total knee replacement")	2,075	90

*Note: These work RVUs are taken from the Medicare Payment Schedule published in the Federal Register on November 25, 1991. They have been multiplied by 100 to assist the rating process.

"A service paid on a global basis includes visits and other services provided in addition to the basic procedure during a specified number of days before and after the procedure is provided. The *glob period* identified above refers to the number of preprocedural and postprocedural days of care that are included in the payment for a global surgical package as determined by the Health Care Financi Administration for Medicare payment purposes. There are three categories of global services (090, 010, 000). In addition, there are two types of alpha global codes that may be used: XXX=Global conce does not apply to code; YYY=Global period to be set by the Medicare carrier; ZZZ=Code is part of another service and falls within global period for other service. Refer to Table 2 for the servic included in each type of global package.

A "separate procedure" is one that is commonly carried out as an integral part of a total service and thus not generally identified separately. In those instances, however, when such a procedure is perform independently of, and is not immediately related to, other services, it may be listed as a "separate procedure."

Survey Form B
Elbow Procedures

ORTHOPAEDIC SURGERY: American Academy of Orthopaedic Surgeons
New or Revised CPT Codes

Number	CPT Code	CPT Descriptor	Type of Revision	Work RVUs* (X 100)	Global Period**	Key Reference Services in Priority Order	Typical Patient and Nature and Extent of Services Provided -- Including any Special Assumptions You Made Rating the Service	About How Many Times in the Last 12 Months Have You Provided This Service?	If Zero, How Many Times Have you Provided the Service in Your Career?
1	240XX	Arthrotomy of the elbow, with capsular excision for capsular release	new code		90				

Note: Work RVUs from the Medicare Payment Schedule published in the Federal Register on November 25, 1991. They have been multiplied by 100 to assist the rating process.

A service paid on a global basis includes visits and other services provided in addition to the basic procedure during a specified number of days before and after the procedure is provided. The *global period* identified above refer to the number of preprocedural and postprocedural days of care that are included in the payment for a global surgical package as determined by the Health Care Financing Administration for Medicare payment purposes. There ar three categories of global services (090, 010, 000). In addition, there are two types of alpha global codes that may be used: XXX=Global concept does not apply to code; YYY=Global period to be set by Medicare carrie ZZZ=Code part of another service and falls within global period for the other service. Refer to Table 2 for the services included in each type of global package.

A "separate procedure" is one that is commonly carried out as an integral part of a total service and thus not generally identified separately. In those instances, however, when such a procedure is performed independently of, an is not immediately related to, other services, it may be listed as a "separate procedure."

Physician Name: _____

Table 1B

ORTHOPAEDIC SURGERY
American Academy of Orthopaedic Surgeons

Reference Services for Elbow Procedures

Number	CPT Code	CPT DESCRIPTOR	Work RVUs (x 100)	Global Period
1	25085	Capsulotomy, wrist (e.g., for contracture)	541	90
2	24102	Arthrotomy, elbow; for synovectomy	797	90
3	24495	Decompression fasciotomy, forearm, with brachial artery exploration	799	90

*Note: These work RVUs are taken from the Medicare Payment Schedule published in the Federal Register on November 25, 1991. They have been multiplied by 100 to assist the rating process.

~A service paid on a global basis includes visits and other services provided in addition to the basic procedure during a specified number of days before and after the procedure is provided. The *global period* identified above refers to the number of preprocedural and postprocedural days of care that are included in the payment for a global surgical package as determined by the Health Care Financing Administration for Medicare payment purposes. There are three categories of global services (090, 010, 000). In addition, there are two types of alpha global codes that may be used: XXX=Global concept does not apply to code; YYY=Global period to be set by the Medicare carrier; ZZZ=Code is part of another service and falls within global period for other service. Refer to Table 2 for the services included in each type of global package.

A "separate procedure" is one that is commonly carried out as an integral part of a total service and thus not generally identified separately. In those instances, however, when such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure."

Components of Physicians' Total Work for Major Surgical Procedures

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Specific components will vary by specific service. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the time it takes to perform the service as well as the three dimensions of the intensity of that time – technical skill and physical effort, mental effort and judgment, and stress associated with your concern about iatrogenic risk.

Work During the Service Is	Before the Service, May Include	After the Service, May Include
Work while you perform the service – "skin-to-skin" work -- or the surgery itself, beginning with the incision and ending with its closure, or the equivalent primary activity for procedures not requiring an incision. This period includes all intra-operative services that are normally included as a necessary part of the procedure.	**Services provided within 24 hours of the operation (generally beginning with the patient's admission to the hospital):** Pre-operative work, including performing the physical exam and history; procedural work-up; compiling data and finalizing specific operative decisions; communicating with other professionals, patient and family; obtaining consent and application of traction/splints and preliminary treatment (*excluding consultation or evaluation at which the decision to provide the procedure was made*). Pre-incisional work in the operating room: including induction of anesthesia; consultations; scrubbing and waiting before surgery; preparing patient and needed equipment for surgery; and positioning the patient. This period begins with the patient's entry into the OR and ends when surgery begins.	Post-incisional work in the operating room, including patient stabilization and awakening; application of post-op monitoring devices; repositioning patient; and transfer to the recovery room or specialized unit. Immediate Post-Operative Period – patient stabilization in the recovery room or special unit – including communicating with the patient and other professionals (including written and telephone reports and orders); application of devices; assessment of neurovascular status; and interpretation of radiographs. Other follow-up care before the patient is discharged, if applicable, including patient visits (includes care for inpatients and outpatients); reviewing status with patient and family; adjusting devices, drains, and dressings; documenting chart; and discharge planning. Post-operative visits within 90 days of the operation, including assessing patient; managing complications; supervising rehabilitation; documenting chart, and communication with family.

1.2 Definition of Work Periods

To evaluate work and time, surgical procedures are divided into seven different periods. Together, these seven periods encompass the entire surgical global bundle interval, as defined in the Medicare Fee Schedule, beginning on the day before surgery and continuing through the 90th post-operative day. For non-global (starred) procedures, the included post-operative period ranges from 0 to 30 days, depending on the procedure.

You should focus separately on each of the following periods as you provide your estimates of work and time for each service you are asked to evaluate. Consider all the activities that you, as the primary surgeon, may perform during each period, remembering that many are frequently accomplished simultaneously. Do not include activities performed by others in your estimates of work requirements.

The descriptions of each period include activities that are only relevant for certain procedures. Activities are listed only to assist you in thinking about the work you perform in each of the periods and are in no way intended to reflect suggested guidelines.

Pre-Operative Period

Includes activities beginning the day before surgery (generally with the patient's admission to the hospital) and continuing until the patient enters the operating room. This period may include the following activities:

- Compile data and finalize specific operative decisions
- Perform physical examination and history
- Hold pre-operative discussions with patient and family, obtain informed consent
- Review pre-operative planning & consultations with other medical staff
- Inventory, order, and assemble special equipment
- Apply traction, splints
- Provide preliminary treatment (e.g., closed reduction)

The pre-operative period *excludes* any initial evaluative consultation, which may be billed separately. Assume that this evaluation has been completed before the global period begins.

Pre-Incisional Operating Room Period

This period begins with the patient's entry into the operating room and continues until surgery (skin-to-skin period) begins. It may include the following activities:

Induction of Anesthesia:

- Assist anesthesiologist or administer anesthesia
- Inventory surgical environment:
  - Verify presence and condition of appropriate equipment, transfusion
  - Check tourniquet(s)
  - Check photographic equipment/microscope/video arthroscopy scope
  - Verify presence of staff to operate C-arm
- Set up fracture table
- Check patient for skin pressure points
- Review x-rays and lab values

Patient Positioning:

- Remove splints & dressings
- Shave patient
- Insert Foley catheter
- Position patient while protecting vulnerable structures
- Adjust specialized operating table and/or frame
- Perform closed manipulation/reduction
- Apply barrier drapes and specialized monitoring devices (ICP, etc.)
- Insert or remove pins/traction devices (if not included in other procedure)
- Apply DVT devices
- Position C-arm
- Direct and interpret x-ray views
- Apply tourniquet cuff and check pressures

Prepare and Drape the Patient

Other Pre-incisional Activities:

- Scrub
- Don specialized equipment, e.g. AIDS suits, lighting
- Exsanguinize extremities
- Mark incisions
- Set-up equipment (incl. suction)
- Position table and lighting
- Examine patient under anesthesia

Skin-to-Skin Period

This period involves the surgery itself, beginning with the incision and ending with its closure. The primary surgeon may perform some or all of the following activities:

- Make incision
- Perform procedure(s)
- Perform/interpret intraoperative studies, e.g. x-rays, angiography, ultrasound, labs
- Install local or regional anesthesia
- Insert drains/catheters
- Prepare grafts and/or implants & harvest graft materials
- Close incision

Post-Incision Operating Room Period

This period begins upon completion of surgery, i.e. when the incision is closed, and continues until the patient leaves the operating room. It may contain the following activities.

- Apply dressings, splints, casts
- Remove tourniquet(s)
- Apply or remove traction or other protective device (e.g., abduction pillow)
- Apply blood saving device
- Assist anesthesiologist in awakening patient and/or inserting catheter for post-operative pain control
- Protect vulnerable structures during awakening
- Reposition patient (e.g., from frame)
- Transfer patient to bed or stretcher, protecting vulnerable structures
- Position patient on bed
- Assess neurovascular status
- Apply post-operative monitoring or motion device
- Transfer to recovery room or specialized unit

Immediate Post-Operative Period

This period includes the time during which the patient is stabilized in the recovery room or special unit. It may include the following activities:

- Transport from OR
- Write orders, prescriptions, and consultation requests
- Talk to family and primary physician
- Interpret recovery room radiographs
- Assess neurovascular status in recovery room
- Apply DVT devices
- Hook up drains, monitoring devices, and check operation of monitoring equipment

- Interpret results of lab tests (e.g., hematocrit, PO2)
- Dictate operative notes

After this period, the outpatient is discharged and the inpatient is transferred to a room. The next period only applies to inpatients; the following one applies only to outpatients.

Later Post-Operative Hospitalization Period (Inpatient)

This period reflects all activities that occur while the patient is in a non-specialized room, until (s)he is discharged. It comprises all activities associated with visits to the patient which may include the following:

- Assess patient
- Review status with patient, family, other health care personnel
- Manage post-operative complications not requiring return to OR*
- Review labs and x-rays
- Remove drains
- Change dressings
- Adjust traction
- Document chart
- Initiate discharge planning and patient education
- Supervise rehabilitation
- Prepare formal discharge summary

Same Day Care Surrounding Outpatient Discharge (Outpatient)

This period involves services provided to outpatients on the day of surgery and immediately following their discharge from the surgical facility. It may involve the following activities:

- Assess patient
- Review status with patient, family, other health care personnel
- Manage post-operative complications not requiring return to OR*
- Review labs and x-rays
- Document chart
- Initiate discharge planning and patient education
- Supervise rehabilitation
- Call patient at home

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*Treatment of complications requiring a return to the OR is not included in the surgical global bundle and may be billed separately.

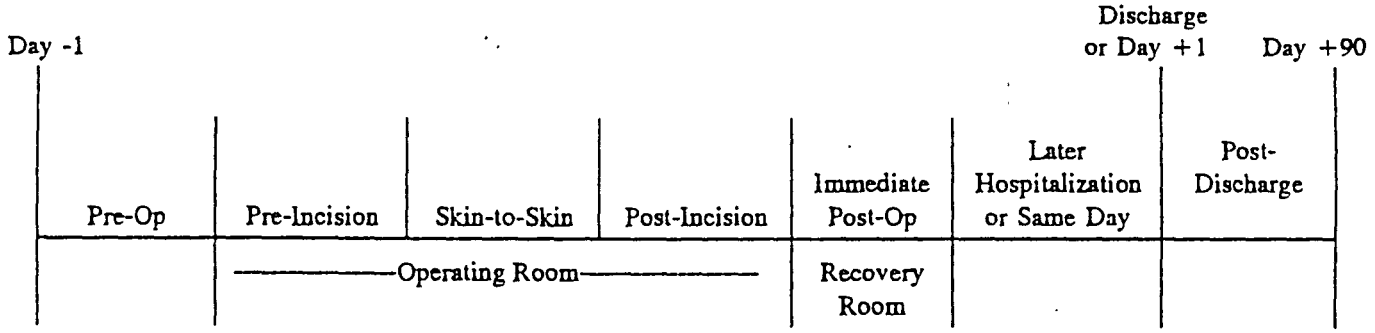
The following period applies to all patients.

Post-Discharge Period

This period begins with an inpatient's discharge from the hospital and on the day following surgery for an outpatient. It continues for 90 days post-operatively for global services, and for shorter intervals for non-global procedures, and involves all visits with the patient. Activities by the primary surgeon may include the following:

- Perform and dictate report on interim history and problem-focused physical
- Counsel patient
- Direct rehabilitation
- Provide appropriate dressing, initial cast/cast change, and wound care
- Obtain and interpret radiographs
- Apply and/or adjust traction devices, dynamic splints, and/or orthotics
- Complete insurance forms
- Arrange consultations
- Handle complications (other than those requiring readmission)

A time line, not drawn to scale, shows these seven surgical procedure periods:



ORTHOPAEDIC SURGERY: American Academy of Orthopaedic Surgeons
New or Revised CPT Codes

Number	CPT Code	CPT Descriptor	Pre-Op	Pre-Incision	Skin-to-Skin	Post-Incision	Immediate Post-Op	Other Same Day or Later Inpatient Hospitalization	Post-Op Office
1	24546	Open treatment of humeral supracondylar or transcondylar fracture with or without internal or external fixation; with intercondylar extension							
2	25526	Open treatment of radial shaft fracture with internal and/or external fixation AND open treatment with or without internal or external fixation of distal radio-ulnar joint (Galeazzi fracture/dislocation)							
3	27218	Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)							
4	27228	Open treatment of acetabular fracture(s) involving anterior AND posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, OR single column or transverse fracture with associated acetabular wall fracture; with internal fixation							
5	27244	Open treatment of basilar neck, intertrochanteric, pertrochanteric or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage							
6	27506	Open treatment of femoral shaft fracture with or without external fixation with insertion of intramedullary implant, with or without cerclage and/or locking screws							
7	27509	Percutaneous skeletal fixation of supracondy-lar or transcondylar femoral fracture with or without intercondylar extension							
8	27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension with or without internal or external fixation							
9	27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation							

Number	CPT Code	CPT Descriptor	Pre-Op	Pre-Incision	Skin-to-Skin	Post-Incision	Immediate Post-Op	Other Same Day or Later Inpatient Hospitalization	Post-Op Office
10	27558	Open treatment of knee dislocation, with or without internal or external fixation; with augmentation/reconstruction, with or without primary ligamentous repair							
11	27752	Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipula-tion with or without skeletal traction							
12	27759	Open treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage							
13	27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (i.e. pilon or tibial plafond); with internal or external fixation; of both tibia and fibula							
14	27894	Decompression fasciotomy, leg; anterior and/or lateral AND posterior compartment(s); with debridement of nonviable muscle and/or nerve							
15	29855	Arthroscopically-aided treatment of tibial fracture, proximal (plateau); unicondylar with or without internal or external fixation (includes arthroscopy)							

Elbow Procedure

ORTHOPAEDIC SURGERY: American Academy of Orthopaedic Surgeons
New or Revised CPT Codes

Number	CPT Code	CPT Descriptor	Pre-Op	Pre-Incision	Skin-to-Skin	Post-Incision	Immediate Post-Op	Other Same Day or Later Inpatient Hospitalization	Post-Op Office
1	240XX	Arthrotomy of the elbow, with capsular excision for capsular release							

APPENDIX 3

The "Implied Work" value for the elbow capsulotomy/capsulectomy code, and other codes, will vary dramatically depending upon what reference service is chosen. This is illustrated below; even when a clinically homogenous reference service is chosen discrepant work values may result. The column labelled "MFS Work" shows the current Medicare fee schedule work value, the column labelled "Ratio" shows the ratio of work values derived from the Work Valuation Panel and the Abt Re-study.

Example 1:

Elbow Capsulotomy/Capsulectomy

Reference CPT	Description	MFS Work	Ratio	Implied Work
24354	Fasciotomy of the elbow with stripping	652	2.50	1630
24330	Revision of arm muscles (Steindler)	967	0.73	710

The AAOS proposed work value for the elbow capsulotomy/capsulectomy is 1033.

Example 2:

Closed treatment of femoral shaft fracture, no manipulation (27500)

Reference CPT	Description	MFS Work	Ratio	Implied Work
27244	Intertrochanteric hip fracture	1523	0.50	762
27508	Closed Treat of distal fem fx, med/lat cond	549	1.00	549

The AAOS proposed work value for the femoral shaft fracture is 590.

AAOS New and Revised Codes

Table 1

AMA #	Surv. #		Cpt	Description	Reference Service CPT	Reference Service MFS Work (*100)	Ratio to Ref Code	Implied Work
		New	21815	Open treatment of rib fracture with internal skeletal fixation, each	21825	719	1.00	719
363		New	23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without repair of tuberosity(−ies) with proximal humeral prosthetic replacement	23470	1698	1.23	2094
368		RV	24505	Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction	24515*	1151	0.40	460
371		RV	24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	24515*	1151	1.00	1151
372		New	24516	Open treatment of humeral shaft fracture; with insertion of intramedullary implant, with or without cerclage and/or locking screws	24515*	1151	1.00	1151
380	1	RV	24545	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension	24545*	1281	0.79	1017
381		New	24546	Open treatment of humeral supracondylar or transcondylar fracture with or without internal or external fixation; with intercondylar extension	24545*	1281	1.21	1545
405		New	25520	Closed treatment of radial shaft fracture with dislocation of distal radio−ulnar joint (Galeazzi fracture/dislocation)	24620	697	0.91	634
406		New	25525	Open treatment of radial shaft fracture with internal and/or external skeletal fixation AND closed treatment of dislocation of distal radio−ulnar joint (Galeazzi fracture/dislocation)	24635	1309	0.94	1232
407	2	New	25526	Open treatment of radial shaft fx w/ internal &/or external fixation AND open treatment w/ or w/o internal or external fix. of distal radio−ulnar jt (Galeazzi fx/disloc)	24635	1309	1.41	1849
410		New	25574	Open treatment of radial AND ulnar shaft fractures; with internal or external fixation of radius OR ulna	25575*	981	0.65	636
411		RV	25575	Open treatment of radial AND ulnar shaft fractures; with internal or external fixation of radius AND ulna	25575*	981	1.02	999
301		RV	25605	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation	25605*, 10	571/422	1.14	563
420		New	26608	Percutaneous skeletal fixation of metacarpal fracture, each bone	26607	540	1.00	540
422		RV	26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation,	26665	753	0.73	546
443		New	27191	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation	27222	1154	0.46	531
445		New	27193	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation requiring more than local anesthesia	27222	1154	0.53	608
453		New	27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s) (i.e. pelvic fracture(s) which do not disrupt the pelvic ring), with internal fixation	27222	1154	0.85	986
454		New	27216	Treatment of posterior pelvic ring fracture and/or dislocation with percutaneous skeletal fixation, (includes ilium, sacroiliac joint and/or sacrum)	27222	1154	1.97	2277
455		New	27217	Open treatment of anterior ring fracture and/or dislocation with internal fixation, (includes pubic symphysis and/or rami)	27222	1154	1.58	1822
456	3	New	27218	Open treatment of posterior ring fracture and/or dislocation with internal fixation (includes ilium, sacroiliac joint and/or sacrum)	27222	1154	2.26	2611
459		New	27226	Open treatment of posterior OR anterior acetabular wall fracture, with internal fixation	27222	1154	1.71	1973
460		New	27227	Open treatment of acetabular fracture(s) involving anterior OR posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation	27222	1154	3.29	3795
461	4	New	27228	Open treat. of acetab fx(s) involving ant AND post (2) columns, inc T−fx & both column fx w/complete artic. detach., OR 1 col. or transv. fx w/associated acetb wall fxs w/int fx	27222	1154	5.26	6071
469	5	RV	27244	Open treatment of basilar neck, intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	27244*	1523	0.94	1432
470		New	27245	Open treatment of basilar neck, intertroch, pertroch or subtroch femoral fx w/ an intramedullary implant; w/ or w/o interlocking screws and/or cerclage	27244*	1523	1.23	1868
471		RV	27254	Open treatment of hip dislocation, traumatic, with acetabular wall and/or femoral head fracture, with or without internal or external fixation;	27253	1262	1.44	1822
473		RV	27256	Treatment of spontaneous hip dislocation (developmental, including congenital, or pathological), by abduction splint or traction; any method	27257	507	0.97	492
479		New	27496	Decompression fasciotomy, thigh and/or knee; one compartment (flexor or extensor or adductor)	27600,1	530/526	1.00	528

AAOS New and Revised Codes

Table 1

AMA #	Surv. #		Cpt	Description	Reference Service CPT	Reference Service MFS Work (*100)	Ratio to Ref Code	Implied Work
480		New	27497	Decompression fasciotomy, thigh and/or knee; one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve	27600,1	530/526	1.75	923
481		New	27498	Decompression fasciotomy, thigh and/or knee, multiple compartments	27600,1	530/526	2 00	1055
482		New	27499	Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve	27600,1	530/526	2.75	1451
551		New	27892	Decompression fasciotomy leg; anterior and/or lateral compartments only; with debridement of nonviable muscle and/or nerve	27600,1	530/526	1.75	923
552		New	27893	Decompression fasciotomy, leg; posterior compartment(s) only; with debridement of nonviable muscle and/or nerve	27600,1	530/526	1.75	923
553	14	New	27894	Decompression fasciotomy, leg; anterior and/or lateral, AND posterior compartment(s); with debridement of noviable muscle and/or nerve	27600,1	530/526	2.75	1451
483		RV	27500	Closed treatment of femoral shaft fracture; without manipulation	27502	1003	0.59	590
484		New	27501	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension; without manipulation	27502	1003	0.59	590
486		New	27503	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction	27508	549	1.70	933
489	6	RV	27506	Open treatment of femoral shaft fracture with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	27506*	163	1.03	1679
490		New	27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	27506*	163	0.83	1354
492	7	New	27509	Percutaneous skeletal fixation of supracondylar or transcondylar femoral fracture with or without intercondylar extension	27508	549	1.30	714
494		New	27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension; with or without internal or external fixation	27508	549	2 40	1318
496	8	New	27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension with or without internal or external fixation	27508	549	3.22	1768
505		New	27535	Open treatment of tibial fracture, proximal (plateau); unicondylar with or without internal or external fixation	27532	718	1.29	924
506	9	RV	27536	Open treatment of tibial fracture, proximal (plateau); bicondylar with or without internal fixation	27532	718	1.86	1334
512	10	New	27558	Open treatment of knee dislocation, with or without internal or external fixation; with augmentation/reconstruction, with or without primary ligamentous repair	27557	1665	1.50	2497
517		RV	27750	Closed treatment of tibial shaft fracture; (with or without fibular fracture); without manipulation	27532	718	0.57	411
518	11	RV	27752	Closed treatment of tibial shaft fracture; (with or without fibular fracture); with manipulation, with or without skeletal traction	27532	718	0.71	513
520		RV	27756	Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg pins or screws)	27532	718	0 86	616
521		RV	27758	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plate/screws, with or without cerclage	27532	718	1.29	924
522	12	New	27759	Open treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, includes interlocking screws and/or cerclage	27532	718	1.29	924
539		New	27824	Closed treatment of fracture of weight bearing articular portion of distal tibia, (i.e. pilon or tibial plafond) with or without anesthesia; without manipulation	27816	286	1.00	286
540		New	27825	Closed treatment of fracture of weight bearing articular portion of distal tibia (ie pilon or tibial plafond), w/ or w/o anesthesia; w/ skeletal traction &/OR requiring manip	27818	536	1.06	570
541		New	27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (i e. pilon or tibial plafond), with internal or external fixation of fibula only	27822,3	884/1149	0.84	853
542		New	27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (i.e. pilon or tibial plafond); with internal or external fixation of tibia only	27822,3	884/1149	1 34	1365
543	13	New	27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (i e. pilon or tibial plafond); with internal or external fixation of both tibia and fibula	27822,3	884/1149	1.57	1593
544		New	27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption with or without internal or external fixation	27822,3	884/1149	0.50	512
574		New	28531	Open treatment of sesamoid fracture with or without internal fixation	28530	106	2 00	212
579		New	28576	Percutaneous skeletal fixation of talotarsal joint dislocation; with manipulation	28575	307	1.29	395
586		New	28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	28645	417	0 68	282

AAOS New and Revised Codes

Table 1

AMA #	Surv. #		Cpt	Description	Reference Service CPT	Reference Service MFS Work (*100)	Ratio to Ref Code	Implied Work
590		New	28666	Percutaneous skeletal fixation of interphalangeal joint dislocation; with manipulation	28675	283	0.48	135
593		New	29850	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, w/ or w/o manipulation; w/o internal or external fixation (includes arthrosc)	27540	1304	0.64	839
594		New	29851	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with internal or external fixation (includes arthroscopy)	27540	1304	1.00	1304
595	15	New	29855	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar with or without internal or external fixation (includes arthroscopy)	27532	718	1.29	924
596		New	29856	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)	27532	718	2.20	1580

	Cpt	Global	Description
Trauma Codes			
	23470	090	Arthroplasty with proximal humeral implant (eg, Neer type operation)
RV	24515	090	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage
RV	24545	090	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension
	24620	090	Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head); with manipulation
	24635	090	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head); with or without internal or external skeletal fixation
RV	25575	090	Open treatment of radial AND ulnar shaft fractures; with internal or external fixation of radius AND ulna
RV	25605	090	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation
	26607	090	Closed treatment of metacarpal fracture, single; with manipulation, with internal or external fixation, each bone
	26665	090	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external skeletal fixation
	27222	090	Closed treatment of acetabulum (hip socket) fracture(s); with manipulation with or without skeletal traction
RV	27244	090	Open treatment of basilar neck, intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage
	27253	090	Open treatment of hip dislocation, traumatic, without internal fixation
	27257	010	Treatment of spontaneous hip dislocation (developmental, including congenital, or pathological), by abduction splint or traction; with manipulation requiring anesthesia
	27502	090	Closed treatment of femoral shaft fracture; with manipulation, with or without skin or skeletal traction
RV	27506	090	Open treatment of femoral shaft fracture with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws
	27508	090	Closed treatment of femoral fracture, distal end, medial OR lateral condyle; without manipulation
	27532	090	Closed treatment of tibial fracture, proximal (plateau); with or without manipulation, with skeletal traction
	27540	090	Open treatment of intercondylar spine(s) and/or tuberosity fractures(s) of the knee, with or without internal or external fixation
	27557	090	Open treatment of knee dislocation, with or without internal or external fixation; with primary ligamentous repair
	27600	090	Decompression fasciotomy, leg; anterior and/or lateral compartments only
	27601	090	Decompression fasciotomy, leg; posterior compartment(s) only
	27816	090	Closed treatment of trimalleolar ankle fracture; without manipulation
	27822	090	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip
	27823	090	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
	28530	090	Closed treatment of closed sesamoid fracture
	28575	090	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia
	28645	090	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation
Elbow Code			
	24102	090	Arthrotomy, elbow; for synovectomy

ATTACHMENT 7

THE SOCIETY OF THORACIC SURGEONS

401 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60611-4267
312/644-6610
Fax No. 312/527-6635

June 26, 1992 (revised)

Grant V. Rodkey, M.D.
Chairman, AMA Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Dr. Rodkey:

We are pleased to present the results of The Society of Thoracic Surgeons/American Association for Thoracic Surgery/American College of Cardiology survey of relative work value recommendations for 40 cardiac and thoracic procedures. A total of 39 physicians was surveyed: 24 by the Society of Thoracic Surgeons/American Association for Thoracic Surgery and 15 by the American College of Cardiology. These represented a balanced proportion of academic and clinical practice-based physicians, evenly distributed in the major geographic areas of the country.

Twenty-two responses were received overall. Since not all physicians performed all of the procedures surveyed, the number of responses for each proposed code varied, and thus, individual response rates were tabulated.

Background

The STS/AATS has now surveyed its members a total of three times with regard to relative work values for cardiothoracic procedures. The first survey was done by Abt Associates in May 1990 with final report released in Sept. 1990. The Abt study, which was done by an independent body under scrupulously controlled conditions, developed a complete, resource-based relative value scale for cardiothoracic and vascular surgery. The Abt study differed substantially from the Hsaio study in its relative value determinations, finding that many cardiac and thoracic procedures were undervalued.

In early 1992 a Delphi study of relative work values for cardiothoracic procedures was conducted within the specialty, and on March 20, 1992, a report based on this study was submitted to HCFA. Now, in June 1992, we are submitting the results of a third survey of cardio-

to the CPT code describing the grafting procedure. In 1993, the descriptor for CPT 33530 will also encompass cardiac valve redo procedures, thus making the code more of a generic open-heart surgery redo code.

We believe that the relative value assigned to identify the work of this new mix of services must be based on the increased work involved in the redo of a heart valve. This procedure includes many of the same high-risk, high-intensity elements of a redo coronary graft, such as a reopening of the sternum and lysis of adhesions in the chest wall. However, replacing a valve requires dissection of the heart muscle, and therefore, in a redo valve, additional scar tissue must be managed in an effort to expose the initial valve. This aspect of the valve redo surgery is unique and requires greater work effort than the redo for grafts. Cardiovascular surgeons have long supported this generic cardiac redo concept. Our expectation is that the RVU assigned to CPT 33530 will represent an average of these services.

The STS/AATS/ACC survey results yielded a work value of 1800. The current MFS value is set at 618, only one-third of our estimated value. Our technical advisory committee adjusted the estimate down to a value of 1200, recognizing the overall mix of redo services. We appreciate the opportunity to provide a more accurate estimate for this service, as the addition of the redo for valves significantly increases the overall value of this service.

Coronary artery bypass grafting procedures

STS/AATS and ACC have spent five years attempting to get codes established in the CPT that accurately reflect the use of saphenous veins and arterial grafts in coronary artery bypass operations. In 1992, working closely with the AMA CPT Editorial Panel, a revised set of coronary artery bypass grafting (CABG) codes were adopted.

The CPT codes for reporting CABG procedures now reflect the true picture of how these operations are done, that is, with saphenous veins only; with arterial grafts (e.g. internal mammary, gastroepiploic or epigastric arteries) only; or with combinations of venous and arterial grafts. We estimate that approximately 80% of the coronary artery bypass operations done today are combination saphenous vein and arterial grafting procedures.

The combination grafts are reported with two CPT codes, one for the venous grafting and one for the arterial grafting, but, since they are viewed as a single procedure, they received only one RVU estimate in the survey. Table 1 contains the language approved by the CPT Editorial Panel for CABG procedures and instructions on reporting these codes. Table 2 is a sample page demonstrating how the combined CABG procedures were described in the AMA/RUC survey.

Cardiac surgeons universally agree that a higher degree of time, intensity, skill, and effort is involved in doing the combined procedures and the arterial grafting procedures than in doing the venous grafting. Arterial grafts, which have proven longer patency, are more fragile, more difficult to harvest, and more difficult to suture because of their delicacy. This is

reflected in the higher work values assigned to these two types of procedures in the AMA/RUC survey.

Comparative data for one procedure, CPT 33510 Coronary artery bypass, autogenous graft (e.g., saphenous vein or internal mammary artery); single graft, yields the following:

Medicare final rule recommendation for CPT 33510 = 23.67
Abt RVU for CPT 33510 = 32.93
Delphi study-based RVU recommended to HCFA for CPT 33510 = 28.00
AMA/RUC survey for CPT 33510 = 29.10

In the Delphi and AMA/RUC surveys, CPT 33510 was based on the upcoming 1993 descriptor, which does not include the internal mammary artery graft. The Abt study is based on the older descriptor, which does include the internal mammary artery. This explains the higher value from the Abt recommendations.

Although the MFS RVU technically includes the IMA in the descriptor, we believe that most surgeons, in an attempt to correctly report combination venous and arterial grafts, have been adding modifier -22 to 33510 (and all analogous CABG codes). Thus, 33510, reported from the MFS without a modifier is tantamount to a single venous graft. Therefore, we think that the MFS, Delphi, and AMA/RUC recommendations are, in effect, addressing the same procedure, a single venous graft.

Survey instrument and reference procedures

Survey respondents used the magnitude estimation methodology for assigning work values. Under this method, seven selected CPT codes were used as reference points to help guide survey value estimation. The seven codes chosen as references had assigned work values that were agreed upon by HCFA, STS/AATS, and ACC. The reference procedures are listed in Table 3.

The great majority of respondents referenced the new and revised procedures under consideration to CPT Codes 32100, 35301, and 35081, including combinations and multipliers.

Patient descriptions

CABG Codes (Tracking Nos. 144-159)

Patients undergoing coronary artery bypass grafting are increasingly elderly men and women with unstable or postinfarction angina. (Patients with mild to moderate angina are currently treated with coronary angioplasty.) These are often complicated by previous myocardial infarction, diabetes, hypertension, renal failure, chronic obstructive pulmonary disease, previous CABG or other open-heart surgery, and peripheral vascular disease. These people range from ill to very ill, and the procedures are frequently done on an emergency basis.

Reoperation for CABG and heart valves (Tracking No. 0024)

Patients undergoing redo operations for coronary artery disease are described above, but note that they are usually older and more ill than individuals undergoing initial bypass grafting. Patients undergoing redo valve operations range in age from young to elderly and suffer from mitral, aortic, or tricuspid disease caused by infection, ventricular dysfunction, aneurysm, aging and inflammation. They are often older and usually much more ill than individuals getting an initial valve replacement. They often have complications such as coronary artery disease or other cardiac pathology, bleeding, hypertension, aneurysmal disease, coagulopathies, and active infection.

Repair of coronary arteriovenous fistula (Tracking Nos. 0004-0005)

Patients with coronary arteriovenous fistula range in age from the very young with a congenital heart defect such as a left-right shunt to middle-aged to elderly patients with progressive cardiac failure. They may be asymptomatic or quite ill. Symptoms include heart murmur, fatigue, acute onset of congestive heart failure, The condition itself is ultimately life-threatening and must be corrected as soon as it is discovered.

Omental flap (Tracking No. 0006)

Patients needing this procedure are seriously ill middle-aged to elderly and often will have had chest wall tumors or invasion of the chest wall with lung cancer. The majority have had infections of the chest wall, resulting in sternal dehiscence, or mediastinitis following surgery or trauma. The procedure requires a separate celiotomy and closure and takedown and manipulation of the flap to accomplish the repair.

Aortic suspension (aortopexy) (Tracking No. 160)

This would be used in a patient needing decompression of trachea, such as occurs in children with tracheomalacia.

Frequency of procedures

The coronary bypass grafting operations and cardiac redo procedures are high volume operations. Approximately 400,000 coronary artery bypass graft procedures are performed in the United States each year. Of these, about 30% are redo procedures.

Some of the procedures requiring new codes are done infrequently, and the physicians responding to this portion of the survey indicated that they did no more than 2 of those procedures in a year's time.

Some of the procedures requiring new codes are done infrequently, and the physicians responding to this portion of the survey indicated that they did no more than 2 of those procedures in a year's time.

Statistical analysis

The data were analyzed with means, medians, and standard deviations, of the responses derived for each of the 40 codes. Mean RVUs are reported in Table 4, along with recommended work values. The compiled results were finally reviewed by a technical advisory committee of experienced surgeons for face validity (See Table 4 for committee adjustment numbers).

Note that the incremental work for venous grafting alone is based on an algorithm resulting in an additional two RVUs for each additional venous graft. For arterial grafting alone, the increment in work values is three additional RVUs for each additional arterial graft. For combination grafting, the addition of <u>each</u> venous graft to the basic arterial graft code represents an increase of two RVUs per venous graft.

Sincerely,

Sidney Levitsky M.D./jf

Sidney Levitsky, M.D.
Chairman, STS/AATS Committee on Nomenclature & Coding
Surgical Representative, ACC Coding and Nomenclature Committee

Table 2.

VENOUS GRAFTING ONLY FOR CORONARY ARTERY BYPASS

The following codes are used to report coronary artery bypass procedures using venous grafts only. These codes should NOT be used to report the performance of coronary artery bypass procedures using arterial grafts and venous grafts during the same procedure. See [illegible] grafts.

335XX Coronary artery bypass, vein only; single coronary venous graft

335XX two coronary venous grafts

335XX three coronary venous grafts

335XX four coronary venous grafts

335XX five coronary venous grafts

334XX six or more coronary venous grafts

(For separate procurement of graft, add modifier -62, services rendered by two surgeons, or use 09962)

COMBINED ARTERIAL-VENOUS GRAFTING FOR CORONARY BYPASS

The following codes are used to report coronary artery bypass procedures using venous grafts and arterial grafts during the same procedure. These codes may NOT be used alone.

To report combined arterial-venous grafts it is necessary to report two codes: 1) the appropriate combined arterial-venous graft code (335XX-335XX); and, 2) the appropriate arterial graft code (335XX-335XX).

- 335XX Coronary artery bypass, using venous grafts(s) and arterial graft(s); single vein graft (list separately in addition to code for arterial graft)

- 335XX two venous grafts (list separately in addition to code for arterial graft)

- o 335XX three venous grafts (list separately in addition to code for arterial graft)
- o 335XX four venous grafts (list separately in addition to code for arterial graft)
- o 335XX five venous grafts (list separately in addition to code for arterial graft)
- o 335XX six or more venous grafts (list separately in addition to code for arterial graft)

ARTERIAL GRAFTING FOR CORONARY ARTERY BYPASS

The following codes are used to report coronary artery bypass procedures using arterial grafts only and combined arterial-venous grafts. The codes include the use of the internal mammary artery, gastroepiploic artery, epigastric artery, radial artery, and arterial conduits procured from other sites.

To report combined arterial-venous grafts it is necessary to report two codes: 1) the appropriate arterial graft code (335XX-335XX); and, 2) the appropriate combined arterial-venous graft code (335XX-335XX).

- o 335XX Coronary artery bypass, using arterial graft(s); single arterial graft
- o 335XX two coronary arterial grafts
- o 335XX three coronary arterial grafts
- o 335XX four or more coronary arterial grafts

Tracking Number	CPT Code	CPT Descriptor	Type of Revision	Work RVU	Global Period	Key Reference Services in Priority Order	Typical Patient and Nature and Extent of Procedure — Including any Special Assumptions You Made Rating the Service	How Many Times in the Last 12 Months Have You Performed This Service?	How Many Times Have You Performed the Service in Your Career?
154a	335XX*	Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (list separately in addition to code for arterial graft) AND: Coronary artery bypass, using arterial graft(s); single arterial graft	New CABG codes for venous and arterial grafts during same procedure		090				
154b		Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (list separately in addition to code for arterial graft) AND: Coronary artery bypass, using arterial graft(s); two coronary arterial grafts			090				
154c		Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (list separately in addition to code for arterial graft) AND: Coronary artery bypass, using arterial graft(s); three coronary arterial grafts			090				
154d		Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (list separately in addition to code for arterial graft) AND: Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts			00				

Table 2.

Table 3.

THORACIC SURGERY
Society of Thoracic Surgeons

Reference Services

Number	Procedure	CPT DESCRIPTOR	Work RVUs (x 100)	Global Period
1	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family	146	XXX
2	99223	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit	254	XXX
3	35460	transluminal angioplasty, open; venous	637	000
#4	32100	thoracotomy, major with exploration and biopsy	1061	090
#5	35301	thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision CEA	1707	090
#6	33500	repair of coronary arteriovenous or anterioventricular chamber fistula	2227	090
#7	35081	direct repair of aneurysm, false aneurysm or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, false aneurysm or occlusive disease, abdominal aorta	2335	090

Note: These work RVUs are taken from the Medicare Payment Schedule published in the Federal Register on November 25, 1991. They have been multiplied by 100 to assist the rating process.

*A service paid on a global basis includes visits and other services provided in addition to the basic procedure during a specified number of days before and after the procedure is provided. The global period identified above refers to the number of preprocedural and postprocedural days of care that are included in the payment for a global surgical package as determined by the Health Care Financing Administration for Medicare payment purposes. There are three categories of global services (090, 010, 000). In addition, there are two

Table 4. Society of Thoracic Surgeons/American Association for Thoracic Surgery/American College of Cardiology

Summary of Survey Results - Mean RVUs

Section A: STS/AATS/ACC combined analysis
SAMPLE SIZE: 39

TRACKING NUMBER: 0024
CPT CODE: 33530
CPT DESCRIPTOR: Reoperation, coronary artery bypass or valve procedure, more than one month after original operation (listed separately in addition to code for primary procedure) (Use 33530 only for codes 33400-33478; 33510-33516 (Basic procedures include endarterectomy or angioplasty).

RESPONSES: 19

MEAN RVU: 1866

Committee Adjustment: 1200

TRACKING NUMBER: 150a
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s) and single arterial graft.

RESPONSES: 13

MEAN RVU: 3098

Committee Adjustment: 3100

TRACKING NUMBER: 150b
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); two coronary arterial grafts.

RESPONSES: 13

MEAN RVU: 3439

Committee Adjustment: 3500

TRACKING NUMBER: 150c
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); three coronary arterial grafts.

RESPONSES: 13

MEAN RVU: 3704

Committee Adjustment: 3800

TRACKING NUMBER: 150d
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts.

RESPONSES: 13

MEAN RVU: 3967

Committee Adjustment: 4000

TRACKING NUMBER: 151a
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); single arterial graft.

RESPONSES: 13

MEAN RVU:	**3305**
Committee Adjustment:	**3300**

TRACKING NUMBER:	151b
CPT CODE:	335XX
CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); two arterial grafts.
RESPONSES:	13
MEAN RVU:	**3545**
Committee Adjustment:	**3600**

TRACKING NUMBER:	151c
CPT CODE:	335XX
CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); three arterial grafts.
RESPONSES:	12
MEAN RVU:	**3854**
Committee Adjustment:	**3900**

TRACKING NUMBER:	151d
CPT CODE:	335XX
CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); four or more arterial grafts.

RESPONSES:	12
MEAN RVU:	**4089**
Committee Adjustment:	**4100**

TRACKING NUMBER:	152a
CPT CODE:	335XX
CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); single arterial graft.
RESPONSES:	13
MEAN RVU:	**3428**
Committee Adjustment:	**3500**

TRACKING NUMBER:	152b
CPT CODE:	335XX
CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); two arterial grafts.
RESPONSES:	13
MEAN RVU:	**3559**
Committee Adjustment:	**3800**

TRACKING NUMBER:	152c
CPT CODE:	335XX
CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (list separately in addition to code for arterial graft: AND Coronary artery bypass,

using arterial graft(s); three arterial grafts.

RESPONSES: 12

MEAN RVU: 4036

Committee Adjustment: 4100

TRACKING NUMBER: 152d
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); three venous grafts (list separately in addition to code for arterial graft: AND Coronary artery bypass, using arterial graft(s); four or more coronary grafts.

RESPONSES: 12

MEAN RVU: 4312

Committee Adjustment: 4400

TRACKING NUMBER: 153a
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); single arterial graft.

RESPONSES: 13

MEAN RVU: 3593

Committee Adjustment: 3700

TRACKING NUMBER: 153b
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts

(list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); two arterial grafts.

RESPONSES: 12

MEAN RVU: 3879

Committee Adjustment: 4000

TRACKING NUMBER: 153c
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); three arterial grafts.

RESPONSES: 12

MEAN RVU: 4188

Committee Adjustment: 4300

TRACKING NUMBER: 153d
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); four venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); four or more arterial grafts.

RESPONSES: 12

MEAN RVU: 4439

Committee Adjustment: 4500

TRACKING NUMBER: 154a
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (list separately in addition to code for

arterial graft) AND Coronary artery bypass, using arterial graft(s); single arterial graft.

RESPONSES: 13

MEAN RVU: **3754**

Committee Adjustment: **3900**

TRACKING NUMBER: 154b
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); two arterial grafts.

RESPONSES: 12

MEAN RVU: **4049**

Committee Adjustment: **4200**

TRACKING NUMBER: 154c
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); three arterial grafts.

RESPONSES: 12

MEAN RVU: **4320**

Committee Adjustment: **4500**

TRACKING NUMBER: 154d
CPT CODE: 335XX

CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); five venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); four or more arterial grafts.
RESPONSES:	12
MEAN RVU:	**4571**
Committee Adjustment:	**4700**

TRACKING NUMBER:	155a
CPT CODE:	335XX
CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); single arterial graft.
RESPONSES:	13
MEAN RVU:	**3669**
Committee Adjustment:	**4100**

TRACKING NUMBER:	155b
CPT CODE:	335XX
CPT DESCRIPTOR:	Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); two arterial grafts.
RESPONSES:	12
MEAN RVU:	**4279**
Committee Adjustment:	**4400**

TRACKING NUMBER: 155c
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); three arterial grafts.

RESPONSES: 12

MEAN RVU: **4526**

Committee Adjustment: **4700**

TRACKING NUMBER: 155d
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using venous graft(s) and arterial graft(s); six or more venous grafts (list separately in addition to code for arterial graft) AND Coronary artery bypass, using arterial graft(s); four or more arterial grafts.

RESPONSES: 12

MEAN RVU: **4736**

Committee Adjustment: **4900**

TRACKING NUMBER: 156
CPT CODE: 335XX
CPT DESCRIPTOR: Coronary artery bypass, using arterial graft(s); single arterial graft

RESPONSES: 21

MEAN RVU: **3262**

Committee Adjustment: **3100**

TRACKING NUMBER: 157
CPT CODE: 335XX

CPT DESCRIPTOR: two coronary arterial grafts
RESPONSES: 21

MEAN RVU: 3507

Committee
Adjustment: 3400

TRACKING NUMBER: 158
CPT CODE: 335XX
CPT DESCRIPTOR: three coronary arterial grafts
RESPONSES: 21

MEAN RVU: 3928

Committee
Adjustment: 3700

TRACKING NUMBER: 159
CPT CODE: 335XX
CPT DESCRIPTOR: four or more coronary arterial grafts
RESPONSES: 21

MEAN RVU: 4268

Committee
Adjustment: 4000

TRACKING NUMBER: 160
CPT CODE: 335XX
CPT DESCRIPTOR: Aortic suspension for tracheal decompression e.g., for tracheomalacia (separate procedure)

RESPONSES: 18

MEAN RVU: 1766

Committee
Adjustment: 1600

ATTACHMENT 8

SOCIETY OF CARDIOVASCULAR & INTERVENTIONAL RADIOLOGY

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June 17, 1992

Mark J. Segal, Ph. D., Director
Department of Health Care Financing and Organization
American Medical Association
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Dear Dr. Segal,

We would again like to thank you for soliciting the input of the Society of Cardiovascular and Interventional Radiology (SCVIR) in the valuation of several new CPT codes. Because our physicians typically have the most expertise in procedures involving image-guided intervention, we believe that we are uniquely qualified to rate these procedures. We look forward to presenting our results at the RVS Update Committee (RUC) meeting on June 25 - 27, and to continuing to contribute to the ongoing process of improving the Fee Schedule.

This letter summarizes the results of the RUC Advisory Committee (the Committee) survey to value 54 new CPT codes, which was carried out under the guidance and supervision of Lewin-ICF. The methods used to estimate values and the resulting recommended values are described in this introduction. To simplify this process, we have grouped the 54 codes which were valued into 14 groups of similar types of services, as shown in the table below.

The balance of this letter describes the procedures that we valued, and the analogous codes used to arrive at work RVUs. We first describe the codes from three groups which, we believe, should not be changed from their current valuation. All of these procedures were valued through the standard magnitude estimation technique, and the small changes in nomenclature adopted by the CPT editorial panel should not affect these values. We then describe the remaining eleven groups of procedures which have new or significantly changed CPT descriptions, thus meriting valuation.

Methods Used to Estimate Work RVUs

The methods used to determine the values reported above were obtained from your letter of June 5th. We used the survey provided by the AMA, and included a cover letter from the committee chair explaining the valuation process. To ensure that an adequate sample was obtained, the committee chair identified a number of physicians who were not on the committee, but were expert in the procedures being surveyed. The survey was completed by fourteen physicians expert in the field of interventional radiology.

The survey results were compiled by Lewin-ICF, and summarized for the use of the committee. In addition to the median and mean work RVUs, the committee's materials included the number of times the physician performed the procedure in the last 12 months, key reference services used, and the fraction of times the old code would be replaced by the new code. Final recommendations were then determined by conference call. Nine of the surveyed physicians participated in the call, including the experts who were added to the committee for the purpose of valuing certain procedures. We used the median and mean survey values as a starting point to determine the appropriate values for the two codes in question. After the discussion of each code, the final values were determined by the consensus process.

For certain groups of procedures, the committee determined that experience in carrying out a type of procedure was a better measure of "fitness to rate" than experience in carrying out one given procedure. For this reason, aggregated frequencies are reported for the following groups of procedures: open and percutaneous balloon angioplasty codes (0023a - 0023z), open and percutaneous atherectomy codes (0023o - 0023z), angioplasty supervision and interpretation codes (0023aa - 0023ee), atherectomy supervision and interpretation codes (0023ff - 0023jj), the placement of needle localization wire, breast lesion localization (138 and 139), and intravascular stents (163 - 166).

The final values for each procedure are summarized in Appendix A, along with key reference services used in evaluating the procedures, and the mean number of times per year the physicians performed each type of procedure. The codes to be used for historical crosswalks are summarized in Appendix B. Finally, a one page description of the survey results and consensus process for each code is included as Appendix C. We are currently completing this appendix, and it will follow under separate cover.

II. Relative Valuation of New Services or Those With a Significant Change in Nomenclature

The following 11 groups of services were valued by the survey instrument as constructed by the AMA and were then subjected to a small group consensus conference. Where there was a significant disagreement among survey respondents or where the values were discrepant from procedures considered analogous, the group discussed those procedures and values. In some cases this resulted in a change in valuation. In no cases did these changes result in an increase or decrease of values beyond the range of values obtained by survey.

A. Tracking Numbers 0023o-z: Peripheral Atherectomy.

The panel had some difficulty recommending values for these procedures because the approved CPT codes do not adequately describe the procedures in question. The codes requested by the SCVIR were for atherectomy first vessel and atherectomy each additional vessel. We made no distinction between open or percutaneous, and did not attempt to maintain anatomic symmetry with the angioplasty codes in the SCVIR request, primarily because atherectomy in some of the anatomic sites currently treated by angioplasty is either unheard of or extremely infrequent at best. We therefore had difficulty in assigning values to many of the codes granted by the Editorial Panel.

Atherectomy is performed in two general clinical scenarios; as a primary or "stand-alone" procedure and as a secondary service in the face of a complication from angioplasty. The work by way of time, risk, skill, effort, judgment, and stress is different in these two situations. In the group of physicians surveyed, it was noted that some individuals performed atherectomy as a primary procedure 95% of the time, while in other practices atherectomy was performed as a secondary procedure in 80%-95% of cases. There was also some confusion with regard to the conventions for use of these codes with regard to the inclusion of access, selection, concomitant diagnostic services, and preceding or following therapeutic services. For ease of survey and for the maintenance of consistency in the newly instituted component coding system for interventional services, it was decided to value these services as analogs to angioplasty and to use the very same conventions for use as are currently approved for the angioplasty services.

The preprocedural and postprocedural work is as described above for angioplasty. In addition, as angioplasty is the "gold standard" for percutaneous intervention, considerable thought is mandatory in choosing those cases where primary atherectomy might offer advantages over angioplasty or where atherectomy might be of value as an adjunct to angioplasty. Therefore, preprocedural planning time might be increased over angioplasty services. The intraprocedural work is similar to the description for angioplasty as well. Some atherectomy devices are used to primarily recanalize an occluded vessel. In this scenario, the procedure is akin to the passage of a wire guide through an obstruction. In other cases, the atherectomy is used to primarily treat a luminal narrowing. The risk of dissection is somewhat less than with angioplasty. The size of the entry sheath is larger and therefore the risk of hematoma, pseudoaneurysm formation, and vessel occlusion is somewhat greater and the time required to achieve hemostasis may be increased as well. As there is a lesser chance of dissection, subsequent passages of the atherectomy device is technically easier than multiple passes of a wireguide and angioplasty balloon catheter. The time for the atherectomy procedure is usually longer than a comparable angioplasty procedure.

In the case of atherectomy used as an adjunct to angioplasty, the procedure is shorter than a primary atherectomy, but the passage of the device through intimal flaps and dissections is more treacherous. The procedure has some redundancy with the antecedent angioplasty and will obviously be subjected to the multiple surgery decrease in payment policy. Despite this, the valuation for atherectomy in this setting should be decreased as compared with primary atherectomy.

Open atherectomy as open angioplasty is generally performed during vascular access for another operative procedure. In many institutions, the interventionalist attends in the operating room with a surgeon. In these cases, the surgeon is performing the open operative procedure (a graft of some type, in most cases) and the interventionalist then performs the atherectomy through the incision used for the primary surgical procedure. In other institutions, the operating surgeon performs both services. In the case of some large bore atherectomy devices, the open approach is used to place the device without any other operative procedure planned in conjunction. This is by far the more rare occasion. This should occur slightly more frequently with atherectomy than with angioplasty because of device size. Routine open vascular access for most angioplasty or atherectomy devices is not necessary.

Because of these considerations, the surveyed physicians valued open and percutaneous atherectomy exactly equally with regard to work RVUs just as open and percutaneous

angioplasty are valued exactly the same with regard to work RVUs. The survey results revealed a dichotomy of values, however. This was due to the disparity in use between primary and secondary atherectomy. As well some confusion was introduced because of the theoretical nature of several of the atherectomy procedures as noted above. These issues were resolved by the consensus conference as follows.

First, it was decided to value the procedures as a blend of the two general types, primary and secondary. In the case of secondary procedures, they would be coded in addition to the primary (usually angioplasty) procedure. The SCVIR would be pleased to supply data to indicate the expected frequency with which these services should be provided as secondary procedures so that possible abusive coding practices may be monitored. As such, the value assigned is lower than would be expected if the procedure was to be used as a primary procedure only or if it were to include any antecedent or subsequent angioplasty. It was the expert panel's opinion that to value the procedure otherwise might provide incentive to use a technology more freely than indicated and would not prevent abusive use of these codes in addition to other service codes. The blend of survey values chosen was such that the values for atherectomy are 110% of the analogous angioplasty services.

Second, the panel decided that they would value the theoretical (but as yet unreported) services and the very rarely performed services by applying the same 110% value by comparison to angioplasty even though in these cases actual experience can not be used for obvious reasons. Recommended values for the atherectomy codes are shown in the table below.

Tracking Number	Procedure Code	Descriptor	Final Value	Key References	Mean Frequency of Annual Performance
0023o	354XX	Transluminal peripheral atherectomy, open; renal or other visceral artery	1167	35471 35450	23
0023p	354XX	aortic	801	35472 35452	23
0023q	354XX	iliac	701	35473 35454	23

Tracking Number	Procedure Code	Descriptor	Final Value	Key References	Mean Frequency of Annual Performance
0023r	354XX	femoral-popliteal	854	35474 35456	23
0023s	354XX	brachiocephalic	1101	35475 35458	23
0023t	354XX	tibioperoneal trunk and branches	1001	35470 35459	23

The procedures used as the basis for valuation are the angioplasty codes 35450-35476, and 92982- 92984. The value of these cross-reference procedures should be unaffected by the valuation of atherectomy services as the cross-reference procedures were originally valued by magnitude estimation without inclusion of atherectomy services, because the total volume of atherectomy services is very small as compared with the volume of angioplasty services, and because the difference between the value of the two classes of services (angioplasty and atherectomy) is too small to materially affect the Medicare system.

B. 0023ff-jj: Peripheral Atherectomy Supervision and Interpretation.

These codes were valued by comparison to the analogous angioplasty supervision and interpretation codes. It is unclear as to why renal atherectomy supervision and interpretation services are separated from visceral atherectomy supervision and interpretation services, while they are combined in the analogous angioplasty radiological services. This is especially curious since only a handful of renal atherectomy cases have been performed and reported and no visceral cases have even been reported.

The services are exactly as described in the section dealing with supervision and interpretation work for angioplasty. The surveyed physicians were in complete agreement that the work RVUs should be equal to the analogous angioplasty radiological services. We again do not agree with the values for those services. However, the work involved in these new codes is exactly the same as the work inherent in the existing angioplasty supervision and interpretation services. This left the surveyed physicians and the expert panel involved with the consensus conference little choice but to value the new codes as stated. Recommended values for these codes are shown in the table below.

Tracking Number	Procedure Code	Descriptor	Final Value	Key References	Mean Frequency of Annual Performance
0023ff	759XX	Transluminal atherectomy, peripheral artery, radiological supervision and interpretation	58	75962	25
0023gg	759XX	Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation	37	75968	25
0023hh	759XX	Transluminal atherectomy, renal, radiological supervision and interpretation	138	75966	25
0023ii	759XX	Transluminal atherectomy, visceral, radiological supervision and interpretation	138	75966	25
0023jj	759XX	Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation	37	75968	25

The reference procedures, as stated immediately above were the angioplasty supervision and interpretation codes 75962-75968, and 75978. The values for these cross-reference procedures would not be changed as the values for the revised codes are the same as those already assigned to the reference codes.

G. Tracking Number 171. Cholanglography Through an Existing Catheter (with comments on Needle Cholanglography 47500)

In the current CPT system, there is only one procedural code to describe two very different services. Those are the injection procedures for a cholanglogram by direct puncture of the biliary system by a needle and by opacification of the biliary system through a previously placed indwelling catheter. In the urinary system there are two separate codes for these two types of services. The work involved in providing these types of services is very similar in the biliary and urinary systems. If there is any inaccuracy in this analogy, it is that pyelography by fresh placement of a needle is somewhat easier than is cholanglography because of the size of the target structure. Otherwise there is no substantial difference.

The service includes a review of the patient's medical records and previous laboratory and radiological tests, with careful attention to previous cholangiogram, tests of liver function, and a thorough understanding of the information desired of the injection procedure. In the past, cholanglography was nearly always performed in the postoperative patient to assess for the question of retained biliary stones. This is now the least common indication for this service. The typical patient who is cared for by the delivery of this service has an acute, subacute, or chronic segmental or total, high-grade or complete obstruction of the common or segmental bile ducts. This may be caused by malignancy, scarring from infection, chemotherapy, radiation, or inflammation, or has surgical complications related to fibrosis, clips, or anastomotic narrowing. Some patients do indeed have retained duct stones as well. The purpose of studying these patients is not so much to document the presence of the stones but to plan therapy by way of a percutaneous approach, endoscopy, or reoperation. The indwelling catheter or tube is sterilized. Most patients are also pretreated with antibiotics. Contrast is administered either by direct injection or infusion technique. Care must be taken to avoid increasing the intrabiliary pressure. The patient must be positioned to allow adequate opacification of the entire intrahepatic and extrahepatic biliary system. Delayed visualization of the biliary system is important to evaluate the functional patency of the common bile duct as well as the segmental ducts. After the procedure, the patient's catheter is resecured and the dressing is reapplied. The skin around the chronic catheters requires meticulous care so as to avoid tract infections and ulceration of the surrounding tissue. Possible complications of the procedure include sepsis, contrast reaction, pain, tube malposition or fracture, and inadequate opacification of the system. Total procedure time including pre-, post-, and intraprocedural components is about 30-45 minutes. An operative report is included in the service as well as communication with the referring physician(s) and/or family.

The committee believes that the addition of code 475xx should affect the value of the historical code used to value these procedures, CPT 47500. As discussed above, the expert panel believes that the value of 475xx should be equal to the value of its clear analog, CPT 50394. When splitting out this procedure, only the more complex procedure (which includes needle placement) will remain, and 47500 will only be used to code this procedure. The panel therefore believes that 47500 should be equal to its clear analogue, 50390. This procedure carries an RVU of 342. We recognize that this higher value does not represent a logical weighted average of the two sub-components of the historical code 47500. However, we are unable to recommend a new value based on this methodology, since the historical RVU was not appropriately derived. The SCVIR has addressed this problem with HCFA, and will continue to do so in the future. In the mean time, if the committee decides to change the value of 47500, the work involved in this CPT code should equal that of 50390.

The reference procedures for this valuation as stated above were 50390, 50394, and 47500. The first two codes should not have any adjustment to their work RVUs as they were merely used as analogs and have nothing to do with the reporting of the service valued. The third code is discussed above. The recommended value for code 475XX is shown in the table below.

Tracking Number	Procedure Code	Descriptor	Final Value	Key References	Mean Frequency of Annual Performance
171	475XX	Injection procedure for cholangiography through an existing catheter (e.g., percutaneous transhepatic or T-tube)	217	50394 20501 75848 47500 74305	121

June 23, 1992

Mark J. Segal, Ph.D., Director
Department of Health Care
Financing and Organization
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Segal:

On behalf of the 26,000 physician members of the American College of Radiology (ACR), I am pleased to present our society's physician work relative value recommendations for those recently approved CPT-4 codes that radiologists perform. I will first present our physician work relative value recommendations. Afterwards, survey methodology and individual procedure characteristics will be discussed.

By procedure code, the ACR recommends the following physician work RVUs:

TRACKING CODE #	CPT CODE #	DESCRIPTION	RECOMMENDED WORK RVU
0023U	354XX	Transluminal peripheral atherectomy, percutaneous, renal or other visceral artery	1159 ◆
0023V	354XX	Transluminal peripheral atherectomy, percutaneous, aortic	800 ◆
0023W	354XX	Transluminal peripheral atherectomy, percutaneous, iliac	668 ◆
0023X	354XX	Transluminal peripheral atherectomy, percutaneous, femoral-popliteal	854 ◆
0023Y	354XX	Transluminal peripheral atherectomy, percutaneous, brachiocephalic	1100 ◆
0023Z	354XX	Transluminal peripheral atherectomy, percutaneous, tibioperoneal trunk and branches	1001 ◆
161	360XX	Injection procedure for contrast venography (includes introduction of needle or intracatheter)	180 ◆
163	372XX	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), percutaneous; initial vessel	1253 ◆
171	475XX	Injection procedure for cholangiography through an existing catheter (e.g. percutaneous transhepatic or T-tube)	217 ◆
172	494XX	Injection procedure (i.e., contrast media) for evaluation of previously placed peritoneal-venous shunt (For radiological supervision and interpretation, see 75809)	202.5 ◆
229	759XX	Transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel	124 ◆

TRACKING CODE #	CPT CODE #	DESCRIPTION	RECOMMENDED WORK RVU
0023MM	929XX	Percutaneous transluminal coronary atherectomy, any method, with or without balloon angioplasty; single vessel	1475 ◆
0023NN	929XX	Percutaneous transluminal coronary atherectomy, any method, with or without balloon angioplasty; each additional vessel	561 ◆

◆ The physician work RVUs, so indicated, represent a joint proposal involving the Society of Cardiovascular and Interventional Radiology (SCVIR) and the ACR. The physician work RVUs by procedure as outlined in SCVIR's June 17, 1992 letter have been reconciled, via a teleconference, with the corresponding estimates developed by the ACR.

Methodology

In order to develop relative values for these services a survey was distributed to the members of the General and Pediatric Radiology Economics Committee, the Interventional Radiology Economics Committee, the Ultrasound Economics Committee, and the Committee on Coding and Nomenclature. (The sample size formed from these four committees totaled thirty physicians.) The recipients of the survey were asked to provide estimates of physician work inherent in each new procedure by directly comparing the new service to a series of reference codes. The perceived relationship of physician work in the new services and the reference procedures were measured by magnitude estimation. Furthermore, those radiologists surveyed were asked to rate the clinical appropriateness of each reference code, describe any assumptions contained in their estimates, and indicate their experience with the new procedures by listing the number of times they performed each new procedure (either within a year or within their career).

Ten radiologists (33.3%) responded in time to have their estimates of physician work tabulated (two radiologists responded after the results were generated). Although, at face value, our response rate may seem low, we are confident that an adequate number of responses per procedure was obtained. The radiologists who answered the survey were well distributed geographically (Northeast = 4; South = 2; West = 2; and North Central = 2). In terms of place of practice, the respondents were equally distributed amongst academic and non-academic settings. Because many of the services being evaluated are of a very complex nature and not likely performed except in larger tertiary care hospitals (such as academic centers), the strong showing of academic radiology adds further validity to our results.

The estimates of physician work were presented to the ACR's Commission on Economics (which is comprised of the chairmen of the radiology specialty economics committees), which has final authority over recommending relative values. The work estimates, by reference code, were summarized into quartiles (e.g. 25th percentile, 50th percentile, 75th percentile) and means. Furthermore, statistics weighted by the number of times the respondent had performed the service in question in the last 12 months were also calculated. These statistics were further summarized into single value measures by taking the means and medians of the reference code figures (i.e. the median and means of the reference code quartiles and means were determined). From the estimates provided, Commission members were asked to assign the single work RVU estimate that best described the procedure. This interim step was taken in order to provide an additional level of scrutiny before a final recommendation was prepared. The average of the "best" estimates became our final values. For those services where multiple societies (both within and outside of Radiology) were surveyed, we sought their advice and support towards preparing joint recommendations.

acr

Atherectomy (Tracking Numbers: 0023u-0023jj)

Procedure Description

Atherectomy is performed in two general clinical scenarios; as a primary or "stand-alone" procedure and as a secondary service in the face of a complication from angioplasty. The work by way of time, risk , skill, effort, judgment, and stress is different in these two situations.

All atherectomy services include review of the clinical factors that might encourage or preclude the performance of the procedure such as patient symptoms, noninvasive and/or invasive evaluation, concurrent diseases, activity level, patient expectations, etc. Informed consent is obtained following an explanation of the procedure, its possible risks and benefits. The preprocedural and postprocedural work is similar to that of angioplasty. In addition as angioplasty is the "gold standard" for percutaneous intervention, considerable thought is mandatory in choosing those cases where primary atherectomy might offer advantages over angioplasty or where atherectomy might be of value as an adjunct to angioplasty. Therefore, preprocedural planning time might be increased over angioplasty services.
The patient is premedicated with calcium channel blockers, anti platelet therapy, anticoagulant therapy, and antispasmodic therapy. Sedation and analgesia are also given. All of these activities are directed by the operator. Access into and selection of the appropriate vessel is separately coded and is not part of this service. Should such access already be present (perhaps following diagnostic angiography or a receding intervention such as lysis) it is not recoded. Once the catheter is in place the stenosis (stenoses) or occlusion(s) are negotiated. During this place of the service, vessel dissection is a very real and significant possibility. Should this occur, its management is considered part of the atherectomy service and may entail considerable time and skill (additional 1-3 hours). The device is sized following meticulous measurements of the vessel to be treated. The device is then used to obliterate or remove diseased tissue from the artery or vessel. Multiple passes of the device or devices as necessitated by the initial appearance or hemodynamic evaluation at the lesion may be necessary. These additional atherectomies are not separately coded and are included in the service. Completion angiography is also included in the service and demands not only an evaluation of the site treated but of the distal run off.

Some atherectomy devices are used to primarily recanalize an occluded vessel. In this scenario, the procedure is akin to the passage of a wire guide through an obstruction . In other cases, the atherectomy is used to primarily treat a luminal narrowing. The risk of dissection is somewhat less than with angioplasty. In the case of atherectomy used as an adjunct to angioplasty, the procedure is shorter than a primary atherectomy, but the passage of the device through intimal flaps and dissections is more treacherous. The procedure has some redundancy with the antecedent angioplasty and will obviously be subjected to the multiple surgery decrease in payment policy. If atherectomy is performed at the same setting as angioplasty, both are reported separately. Despite this, the valuation for atherectomy in this setting should be decreased as compared with primary atherectomy.

Following the procedure, the catheter and/or sheath is removed. The caliber of the catheter is larger than a diagnostic device, which may entail a prolonged period of compression to achieve hemostasis. There is also a greater risk of hematoma, pseudoaneurysm formation, and limb ischemia. Should the patient be treated with anticoagulant therapy in the postprocedural period, this must also be managed. Provision of an operative report is also considered part of these services.

These patients in general have multisystem disease with diffuse atherosclerosis and secondary cardiac, renal, and cerebral disorders. The patients are generally elderly with a few notable clinical exceptions. Total procedural time may range from 30 minutes to 4 hours with the majority of the procedures requiring 1-2 hours. A follow-up visit on the day of the procedure is also generally performed. Further follow-up on one's own patient or a consultation patient are separately coded because of the global period of this service. The considerable radiation exposure must also be taken into account when assessing the stress of the services.

The differences among the atherectomy procedures are secondary to the differences in skill level, time, and potential for significant complications when the procedure is performed in various vascular beds. Hence, renal/visceral, brachiocephalic, and tibial-peroneal angioplasty is valued at a greater level than aortic, iliac, and venous procedures. Femoral-popliteal services are intermediate among these services.

These procedures consist of two types of procedures, open and percutaneous. The work inherent in these two types of procedures is similar because of the coding conventions in place with regard to separate coding of access and selection for percutaneous services and the fact that open procedures are generally performed at the time of another service such as graft placement or endarterectomy, which are separately coded as well.

Findings

Percutaneous transluminal angioplasties (35470-35475 for the procedural component and 75962-75966 for the radiological supervision and interpretation) were proven by our survey to be the most clinically equivalent services to atherectomy. For all atherectomy codes taken as a group, the median of the reference code median values were in the range of 1337 (base=100) to 1592 (base=100) for the surgical atherectomy procedure and 86 (base=100) to 158 (base=100) for the radiological supervision and interpretation procedure.

Intravascular Stents (Tracking Numbers: 163 - 166, 229)

Procedure Description

Intravascular stents may be of utility in two general classes of situations. First, the stent may be used as a primary graft in an occluded or severely stenotic vessel. Second, the stent is used to treat a compromised vessel following balloon angioplasty. The only stent currently approved for intravascular use is balloon expandable and that single device is currently approved for use in the iliac artery only. The anatomic utility of these devices is broadening rapidly, however. Treatment of the superior vena caval syndrome in patients who have been subjected to maximal radiation therapy is but one example of the increased indications of this therapy. As well, other types of devices including self-expanding stents are on the immediate horizon.

Access, selection, and contemporaneous therapies are separately coded and are not included in the stent placement service. Therefore, in the case of stents, vascular access already achieved for another diagnostic or therapeutic service would not be recoded and would be subject to the multiple surgery reduction rule. Balloon expansion of a balloon expandable stent would not be separately coded as an angioplasty. However, a preceding angioplasty or access achieved for placement of a stent would be separately coded and paid with reductions for multiple surgeries on the same date of service. Open stent placements are related to percutaneous stent placements in the same way as open angioplasties are related to percutaneous angioplasties.

The placement of the stent begins with the evaluation of noninvasive and invasive evaluation of the patient's arterial system and of the clinical considerations which would encourage or preclude such therapy. The access is generally larger than is necessary for any preceding diagnostic or therapeutic services. Therefore increasing the luminal size of the access sheath is necessary. The patient is treated with increased doses of sedation and analgesia as well as anticoagulants, calcium channel blockers and antispasmodics. All of these therapies are under the primary direction of the operator. The stent is appropriately sized and positioned under fluoroscopic control. The stent is deposited in a manner unique to the individual device in use. The operator must be cognizant of the significantly different characteristics among the various devices that are available with regard to device choice and delivery technique. Follow-up angiography and intravascular pressure gradient measurement are part of this service. The angiography must monitor not only the site treated but the adjacent vessels and the complete run-off vasculature.
After the procedure itself, the access must be removed and hemostasis achieved which requires prolonged manual compression because of the anticoagulant therapy, the size of the access, and the improved pulse pressure. Should the device have been place intraoperatively, there is decreased work as the arteriotomy is closed by a stitch which is a considerably shorter service. On the other hand, should the device have been placed in the absence of surgical access for some other reason (graft or endarterectomy) the procedure times would be equivalent. Appropriate management of the postoperative anticoagulation and other medications as well as the provision of an operative note are included in the service.

Findings

As in the case for atherectomy, percutaneous transluminal angioplasty was viewed by those completing our survey as the most clinically equivalent reference code. The median physician work RVU estimate calculated encompassing all reference codes ranged from 1114 (base=100) to 1300 (base=100) for the surgical component. The radiological supervision and interpretation had a median value of 98 (base=100).

acr

Injection for LeVeen Shunt Patency (Tracking Numbers: 172, 228)

Procedure Description

This procedure is performed in individuals who have a peritoneal-to-venous shunt placed for relief of intractable ascites. The shunt itself consists of tubing which emanates from the peritoneal cavity and ends in a vein, generally the jugular or subclavian vein. Interposed between two segments of shunt tubing is a one-way valve. The purpose of the procedure is to assess the patency of the tubing which leads from the peritoneal cavity to the valve, the tubing which leads from the valve to the vein, the patency of the vein into which the fluid drains, and to assess the proper one-way functioning of the valve.

The patient is interviewed and the medical records are reviewed. In patients who have a history of intercurrent infections or repeated bacterial peritonitis, prophylactic antibiotics are often administered. Informed consent is obtained. The skin overlying the shunt tubing in either one or two locations is sterilely prepared. Local anesthesia is generally given. Intravenous anesthesia is generally not necessary. The shunt is punctured in one or two locations. The number of punctures performed is based upon the findings from the first injection and the clinical concerns which have prompted the study. Water soluble contrast is injected. The shunt is examined both by fluoroscopy and with hard copy films. The egress of contrast into the venous system is noted. The appropriate one-way function of the valve is also evaluated.

Following the procedure the needles are removed. Only brief pressure about the puncture site(s) is generally necessary.

Risks involved with this procedure include the induction of infection which can be life-threatening in these patients, contrast reaction which can also lead to fatality (rarely), and disruption of the shunt which may necessitate its replacement. The procedure itself takes approximately 1/2 hour.

Findings

For purposes of comparison, the best cross reference for code 494XX is code 36145 (Introduction of a needle or intracatheter; arteriovenous shunt created for dialysis). Our survey results, with a median estimate of 212 (base=100), supports this finding by matching the physician work RVU for code 36145 (212).

The radiological supervision and interpretation code most like 758xx is code 78291 (peritoreal-venous shunt patency test) with a median physician work RVU of 93 (base=100).

Transluminal Angioplasty, open or percutaneous

The revision of these codes to state "balloon angioplasty" does not constitute a departure from the way these procedures are currently performed. Therefore, we would oppose a change in physician work RVU.

In closing, we extend our thanks to the RUC for the opportunity to have input into the valuation of these services.

Sincerely,

Emmett O. Templeton, M.D., FACR
Chairman, ACR Commission on Economics

SOCIETY OF CARDIOVASCULAR & INTERVENTIONAL RADIOLOGY

10201 Lee Highway, Suite 160, Fairfax, Virginia 22030 (703) 691-1805 [FAX] (703) 691-1855

July 1, 1992

Mark J. Segal, Ph. D., Director
Department of Health Care Financing and Organization
American Medical Association
515 North State Street
Chicago, Illinois 60610

Dear Dr. Segal,

We greatly appreciate your giving us the opportunity to recommend valuations for the codes representing "each additional" vessel treated by intravascular stent, open / percutaneous. As I mentioned to you, we believe it is of the utmost importance that these two procedures be valued, and that these values be submitted to HCFA so as to assure that they are recognized in the fee schedule in a timely manner.

When these services were originally valued by the SCVIR, those rating the procedures believed that there were two separate operative fields. In light of our discussions with you, we have re-valued those procedures assuming that the services might involve: (1) Two separate operative fields or a single operative field; and (2) Multiple vessels treated might be either contiguous (e.g., ipsilateral common iliac and ipsilateral external iliac) or might be two non-contiguous vessels (e.g., renal artery and iliac artery).

To obtain a reasonable sample, we surveyed 8 physicians expert in this procedure, 5 from academic medical centers, and 3 in private practice. The physicians surveyed represented a broad geographic cross-section of the United States. As a reference procedure, physicians were reminded of the value 12.53 assigned by the RUC to "first vessel stented." Physicians surveyed were instructed that the "each additional" service descriptors would not be subject to the reduction for multiple surgeries on the same date of service. The results were tabulated by Lewin-ICF.

Each physician surveyed believed that the percutaneous and open codes merited the same work valuation. Their values, the median, and the mean are depicted below:

Each Additional Vessel Treated by Stent; Percutaneous / Open
7.50
5.50
6.75
6.26
9.00
6.00
6.26
6.26
Mean: 6.69
Median: 6.26

I would greatly appreciate hearing from you as soon as possible as to the outcome of your deliberations. Of course, if you have any questions, please feel free to call. Thanks again for your willingness to attend to this important matter in such a timely way.

Sincerely,

Gary Dorfman

Gary S. Dorfman, M.D.
Chair, SCVIR Committee on Coding,
Nomenclature, and Relative Valuation.

JUNE 12, 1992

REPORT TO THE

AMERICAN MEDICAL ASSOCIATION
RELATIVE VALUE SCALE UPDATE COMMITTEE

SUBMITTED BY:

ALAN H. BENNETT, M.D.
TECHNICAL ADVISOR
AMERICAN UROLOGICAL ASSOCIATION
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BALTIMORE, MD 21201
410/727-1100

AUA staff tabulated responses to all 3 surveys and submitted this data to the AUA RVS Committee. Detailed information is provided for each of the new CPT codes in Attachment 1.

AUA RVS Committee: The AUA RVS Committee was appointed last December in compliance with the RUC process. This 10-member committee consists of Board-certified urologists with coding and RVS setting expertise. The Committee met on May 8 to deliberate the process and then convened by conference call to review the survey results. The Committee reviewed responses concerning typical patient, key reference procedure and assigned work value. It determined whether the mean value was appropriate or needed modification.

The AUA contacted the American College of Obstetricians and Gynecologists (ACOG) and the Society of Cardiovascular and Interventional Radiology (SCIVR) who will be commenting on the work values submitted by the AUA. Neither Society had hard data available from their surveys and therefore were not able to meet with AUA representatives prior to the submission date. A conference call was convened between the American College of Radiology (ACR) and AUA representatives to discuss tracking codes 242 and 243. Both Societies will be submitting work values for these tracking numbers.

Reference Services List: The opportunity to add procedures to our reference service list was extended to the AUA to better compare certain tracking numbers for the June submission of work values. When these reference services were added, several other procedures were deleted from the reference service list without prior approval by the AUA. Therefore, we ask that the AMA restore the deleted codes to the list. They are as follows:

CODE	DESCRIPTION
50230	Removal of kidney, radical
50590	Fragmenting of kidney stone (ESWL)
50780	Reimplant ureter in bladder
51845	Repair bladder neck
52000	Cystoscopy
52337	Endoscopy of urinary tract, with lithotripsy
52601	Prostatectomy (TURP)
53670	Catheterization, urethra, simple
54640	Suspension of testis

Summary of Recommendations:

Tracking Number	CPT Code/Description	Work RVU (x 100)	Global Period (days)
173	507XX Revision of urinary-cutaneous anastomosis (any type urostomy)	1030	90
174	507XX with repair of fascial defect and hernia	1173	90
175	50780 Ureteroneocystostomy; anastomosis of single ureter to bladder [or other operations for correction of vesicoureteral reflux]	1804	90
176	507XX Ureteroneocystostomy; anastomosis of duplicated ureter to bladder	1920	90
177	507XX with extensive ureteral tailoring	2020	90
178	50785 with vesico-Psoas hitch or bladder flap	2017	90
179	CPT Codes 52320 - 52338 were modified only by an explanatory note indicating insertion of stent is included and should not be reported separately. This CPT action did no affect the work values of these procedures.		
180	52335 Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junctions by any method)	618	90
181	523XX with resection of tumor	930	90
242	93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	230	XXX
243	93981 follow-up or limited study	230	XXX

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #173

NEW CPT CODE:

507XX Revision of urinary-cutaneous anastomosis (any type urostomy);

KEY UROLOGICAL REFERENCE SERVICE:

CPT Code 44314 - Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)

Work RVU - 10.30

RECOMMENDED TOTAL WORK (X 100) FOR 507XX:

1030

RECOMMENDED PLACEMENT IN UROLOGY REFERENCE SERVICES:

Between Reference Service 14 (44314 Revision of ileostomy, complicated) and Reference Service 15 (51860 Cystorrhaphy, suture of bladder wound, injury or rupture; simple)

OTHER INFORMATION CONSIDERED IN DEVELOPING THIS RECOMMENDATION:

Typical Patient: Elderly patient that has had previous major abdominal surgery, probably urinary infection and has a constantly draining stoma. Patient may or may not have received radiotherapy .

Brief Description of Surgical Services: Repair of a complicated colostomy through two fasciae.

Global Period: 90 days

Complexity and Time of New Procedure Compared to Reference Procedure: The amount of work involved in the revision of urinary enterocutaneous anastomosis is equal to the amount of work in the repair or revision of a complicated ileostomy. The pre-operative and the post-operative work will be about the same in the 90-day global period.

Survey Response Rate: 81%

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #174

NEW CPT CODE:

507XX Revision of urinary-cutaneous anastomosis (any type urostomy); with repair of fascial defect and hernia

KEY UROLOGICAL REFERENCE SERVICE:

CPT Code 44346 - Revision of colostomy; with repair of paracolostomy hernia (separate procedure)

Work RVU - 11.73

RECOMMENDED TOTAL WORK (X 100) FOR 507XX:

1173

RECOMMENDED PLACEMENT IN UROLOGY REFERENCE SERVICES:

Between Reference Service 14 (44314 Revision of ileostomy, complicated) and Reference Service 15 (51860 Cystorrhaphy, suture of bladder wound, injury or rupture; simple)

OTHER INFORMATION CONSIDERED IN DEVELOPING THIS RECOMMENDATION:

Typical Patient: Elderly patient that has had previous major abdominal surgery, probably urinary infection and has a constantly draining stoma. Patient may or may not have received radiotherapy .

Brief Description of Surgical Services: Repair of a urostomy and parastomal hernia through the abdominal wall. Repair of these problems require a takedown of the stoma with proximal mobilization of the urostomy often through a different incision and replacement of the urostomy in the same or different stomal locations. Occasionally the ureteral revision is also necessary.

Global Period: 90 days

Complexity and Time of New Procedure Compared to Reference Procedure: The amount of work involved is equal to the amount of work in the revision of a colostomy with the repair of a paracolostomy hernia. The pre-operative work and the post-operative work will be about the same in the 90-day global period.

Survey Response Rate: 81%

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #175

CPT CODE: (Change is only to better define the procedure)

50780 Ureteroneocystostomy, anastomosis of single ureter to bladder, or other operations for correction of vesicoureteral reflux.

TOTAL WORK (X 100) FOR 50780:

1804 - amount of work did not change

EXPLANATION:

CPT Code 50780 is an existing procedure with a work value of 18.04. The word "single" was added to the description of this code to better clarify the procedure. A bilateral procedure would be billed using this code with the appropriate modifier. This amended description represents the work surveyed by Dr. Hsiao and is in agreement with the Work RVU established through that process.

SURVEY RESPONSE RATE: 75%

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #176

NEW CPT CODE:

507XX Ureteroneocystostomy; anastomosis of duplicated ureter to bladder

KEY UROLOGICAL REFERENCE SERVICE:

CPT Code 50785 - Ureteroneocystostomy, with bladder flap

Work RVU - 20.17

RECOMMENDED TOTAL WORK (X 100) FOR 507XX:

1920

RECOMMENDED PLACEMENT IN UROLOGY REFERENCE SERVICES:

Between Reference Service 17 (54304 Revision of penis) and Reference Service 18 (50820 Construct bowel bladder)

OTHER INFORMATION CONSIDERED IN DEVELOPING THIS RECOMMENDATION:

Typical Patient: Pediatric patient with renal obstruction or damage and recurrent and chronic urinary tract infections.

Brief Description of Surgical Services: The operation requires special expertise in the preservation of the ureteral common blood supply and mobilization of duplicated ureters in their common sheath in addition to the standard reimplantation technique.

Global Period: 90 days

Complexity and Time of New Procedure Compared to Reference Procedure: The special nature of these surgical manipulations make the operation similar in complexity to the ureteroneocystostomy with bladder flap procedure, CPT Code 50785.

Survey Response Rate: 81%

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #177

NEW CPT CODE:

507XX Ureteroneocystostomy with extensive ureteral tailoring

KEY UROLOGICAL REFERENCE SERVICE:

CPT Code 50785 - Ureteroneocystostomy, with bladder flap

Work RVU - 20.17

RECOMMENDED TOTAL WORK (X 100) FOR 507XX:

2020

RECOMMENDED PLACEMENT IN UROLOGY REFERENCE SERVICES:

Between Reference Service 17 (54304 Revision of penis) and Reference Service 18 (50820 Construct bowel bladder).

OTHER INFORMATION CONSIDERED IN DEVELOPING THIS RECOMMENDATION:

Typical Patient: Pediatric patient with distal megaureter from obstruction or reflux and recurrent and chronic urinary tract infections.

Brief Description of Surgical Services: The dilated distal ureter is tapered by inserting a sizing catheter into the lumen and removing excess ureter. The ureter is closed around the catheter in 2 layers with sutures. The tapered ureter is reimplanted into the bladder using standard techniques. This is used for megaureter.

Global Period: 90 days

Complexity and Time of New Procedure Compared to Reference Procedure: The time and complexity of this procedure is similar to the ureteroneocystostomy with bladder flap procedure, CPT Code 50785.

Survey Response Rate: 81%

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #178

CPT CODE: (Change is only to better define the procedure)

50785 Ureteroneocystostomy with vesico-Psoas hitch or bladder flap

RECOMMENDED TOTAL WORK (X 100) FOR 50785:

2017 - amount of work did not change

EXPLANATION:

The phrase "vesico-Psoas hitch or" was added to the description of this code to better clarify the procedure. This description represents the work surveyed by Dr. Hsiao and is in agreement with the Work RVU established through his process, 20.17

SURVEY RESPONSE RATE: 75%

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #180

CPT CODE: (Change is only to better define the procedure)

52335 Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junctions by any method)

RECOMMENDED TOTAL WORK (X 100) FOR 52335:

618 - amount of work did not change

EXPLANATION:

The phrase "and/or pyeloureteral junctions" was added to the description of this code to better clarify the procedure. This description represents the work surveyed by Dr. Hsiao and is in agreement with the Work RVU established through his process, 6.18

SURVEY RESPONSE RATE: 70%

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #181

NEW CPT CODE:

5233X Cystourethroscopy, with ureteroscopy and/or pyeloscopy with resection of tumor (includes dilation of the ureter and/or pyeloureteral junctions by any method)

KEY REFERENCE SERVICE:

52338 - Cystourethroscopy, with ureteroscopy and/or pyeloscopy with biopsy and/or fulguration of lesion. Work RVU 7.74

and

43264 - Endoscopic retrograde cholangiopancreatography (ERCP), with or without biopsy and/or collection of specimen; for removal of stone(s) from biliary and/or pancreatic ducts . Work RVU 9.38

RECOMMENDED TOTAL WORK (X 100) FOR 5233X:

930

RECOMMENDED PLACEMENT IN UROLOGY REFERENCE SERVICES:

Between Reference Service 12 (44320 colostomy or skin level cecostomy) and Reference Service 13 (38562 Removal, pelvic lymph nodes).

OTHER INFORMATION CONSIDERED IN DEVELOPING THIS RECOMMENDATION:

Typical Patient: Patient aged 50 to 70 with a urothelial tumor requiring careful biopsy and fulguration with follow-up.

Brief Description of Surgical Services: Under general/spinal anesthesia, a cystoscope is passed transurethrally into the bladder and the ureteral orifice is dilated with a balloon. A guidewire is passed up the ureter and the cystoscope is removed. The ureteroscope (separate instrument) is then introduced into the bladder and passed up the ureter to the lesion or into the renal pelvis. Using a cautery\laser probe or forceps, the tumor is removed. The ureteroscope is then removed. A cystoscope is reintroduced into the bladder and a ureteral stent is passed up the ureter into the kidney and the guidewire is removed.

Global Period: 90 days

Complexity and Time of New Procedure Compared to Reference Procedures: The amount of work involved in this procedure is 20% more than in the urology reference code 52338 and very similar to CPT Code 43264.

SURVEY RESPONSE RATE: 75%

AMERICAN UROLOGICAL ASSOCIATION
RECOMMENDED WORK VALUE FOR TRACKING #242 & #243

NEW CPT CODES:

93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study

93981 Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study

KEY UROLOGICAL REFERENCE SERVICE:

CPT Code 54240 - Penile plethysmography

Work RVU - 2.30

RECOMMENDED TOTAL WORK (X 100) FOR 93980 & 93981:

230

OTHER INFORMATION CONSIDERED IN DEVELOPING THIS RECOMMENDATION:

Typical Patient: Middle-aged to elderly patient experiencing impotency.

Brief Description of Surgical Services: Pulsed Doppler recordings of all four penile vessels are made and are usually repeated after a vasoactive injection.

Global Period: XXX = no globe

Complexity and Time of New Procedure Compared to Reference Procedure: The amount of work involved in this procedure is equal to the amount of work in the penile plethysmography.

Survey Response Rate: 63%

The AUA requested only one code for this procedure and feels that one code would be sufficient. If the Editorial Board prefers to list two codes, the AUA would recommend the same Relative Values for work for both codes.

SOCIETY OF CARDIOVASCULAR & INTERVENTIONAL RADIOLOGY

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June 11, 1992

Gary S. Dorfman, M.D.
Chairman, External Affairs Division
(401) 277-5194
(401) 277-4416 [FAX]

Mark J. Segal, Ph.D.
Director,
Department of Healthcare Financing and Organization
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Segal:

I am writing to you to inform you of the remarkable progress that has been achieved in arriving at a consensus valuation of the new service code for the procedure of transcervical fallopian tube catheterization. As per the telephone conversation that the two of us had during the last week, a conference call among representatives of the American College of Radiology (ACR) and the SCVIR was held on Wednesday, June 10, 1992.

During that call, it was agreed that as suggested by the RUC the value for the preprocedural evaluation and management service would be subtracted from the work RVUs as developed by each of our organizations. The level of service which seemed most appropriate is described by CPT code 99242 Office or outpatient consultation for a new or established patient with an expanded problem focused history and examination and straightforward medical decision making. The validated services as described in the Special Supplement as published by the AMA are not unlike the service provided to these patients and the time estimate of 30 minutes is also as was described in our presentation to the RUC. The work value for 99242 of 1.17 was therefore subtracted form the ACR work value of 5.65 and the SCVIR work value of 6.39. This yielded revised values of 4.48 and 5.22, respectively. An simple arithmetic mean of these two values was then calculated, yielding a value of 4.85. While frequency weighting the mean would have led to a value closer to the SCVIR value, our Society is willing to use the unweighted mean to facilitate the consensus process.

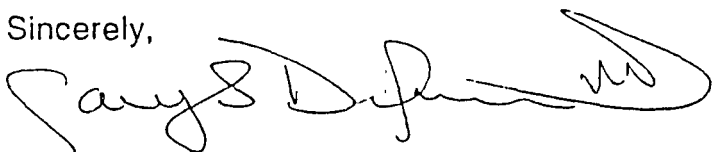
It was noted that the value derived by magnitude estimation survey by the American College of Obstetricians and Gynecologists (ACOG)

was 4.75. As well, review of the ACOG coding request to the CPT Editorial Panel revealed that their original request was for the procedure as described by the SCVIR to the RUC and was unlike the procedure as described and valued by the committee non-survey process used by ACOG which yielded a value of 3.97. Based upon these two facts, it was decided to approach the ACOG with the consensus value as derived above. My understanding is that ACOG now supports this revised value of 4.85.

Based upon this aforementioned scenario, the SCVIR will withdraw our previously submitted value of 6.39 in the spirit of compromise and with the understanding that all the parties that participated in the valuation process now agree to a work RVU of 4.85 for the service.

We appreciate the time and effort that you and your colleagues are expending on our behalf. Thank you for your attention to this matter.

Sincerely,



Gary S. Dorfman, M.D.

cc: Ms. Celeste Kirschner

RUC Evaluation of Tracking Numbers 218 and 219

Tracking Number 218 [61531]

Burr hole(s) for insertion of subdural strip electrodes for long term seizure monitoring.

The National Association of Epilepsy Centers (NAEC) presented this new procedure with a reference to existing 61510 (Craniotomy for excision of supratentorial brain tumor with 24.65 physician work RVUs) and derived a value for this item of 26.00.

It is inappropriate to use a therapeutic craniotomy as the reference for a diagnostic procedure (EEG monitoring) through burr holes, with shorter period of required followup care, but more intensive care during the initial 1-4 weeks.

RUC used 61154 (burr hole(s),unilateral, for evacuation of subdural hematoma), which includes insertion of subdural drains and 90 days postoperative care (12.84 work RVUs) as the best comparable existing procedure and value.

As 61531 is always performed bilaterally through two to four burr holes with separate percutaneous placement of the electrode wires, calculations could then be made by:

	value for 61154	12.84
+	50% for bilaterally performed	6.42
	Accepted value	19.26

Tracking Number 219 [61532]

Burr holes for stereotactic implantation of depth (subcortical) electrodes into the brain for long term seizure monitoring.

The NAEC presented this new procedure with a reference to existing 61780 (stereotactic localization, any method, including burn holes for introduction of subcortical electrodes with MFS physician RVU value of 880) and calculated a value on basis of average of four burr holes by multiplying by 4 to recommend 3200.

RUC applied the conventions of multiple procedures during the same operative sessions according to HCFA regulations of 100% - 50% - 25% - 25%, and then adding value for additional physician time and effort in carrying out the stereotactic activities in the C-T scanner and also in the surgical suite to exactly place the electrodes in various intracerebral sites determined by the computer analysis and the nature of the seizure problem, as described below:

61780	880
61780-51	440
61780-51	220
61780-51	220
30% additional work	528
Accepted Value	22.88

ATTACHMENT 14

ATTACHMENT E

(REVISED)

AMERICAN COLLEGE OF CARDIOLOGY

Recommendations Concerning
Peripheral Vascular Angioplasty and Atherectomy

The American College of Cardiology conducted a survey of cardiologists who perform peripheral vascular angioplasty and atherectomy procedures to assess the relative values of these procedures. As this survey resulted in a fairly low response rate, an accurate analysis of results was not fully available. Therefore, the College offers the following input at this time.

Tracking Numbers 0023a-n: Angioplasty Procedural Services

The 1993 CPT codes for these procedures have been revised to specify balloon angioplasty. Prior to this coding change, these codes covered balloon angioplasty and atherectomy procedures. We believe that this coding change is extremely important for the practice of cardiovascular medicine. At this time, however, we do not think that this coding change alters the current assignment of HCFA work values for this group of procedures. When HCFA assigned the work units to these procedures, the majority of procedures that were coded in this group were balloon angioplasties, therefore, the basis for work units is consistent with the revised coding language. Furthermore, we are not prepared to recommend any changes to the work units for these procedures at this time due to the low response rate from our survey.

Tracking Numbers 0023o-t: Open Transluminal Peripheral Atherectomy

As discussed above, separate codes for peripheral atherectomy are new for the 1993 CPT manual. Only a few of those surveyed had any experience with these services, resulting in a fairly low response rate on this portion of our survey. The American College of Cardiology, therefore, does not offer a recommendation for these services at this time.

Tracking Numbers 0023u-z: Closed Transluminal Peripheral Atherectomy; Supervision and Interpretation Services - Tracking Numbers 0023aa-ee: Angioplasty and Tracking Numbers 0023ff-jj: Peripheral Atherectomy; and Tracking Number 161: Extremity Venography and Tracking Numbers 163-229: Intravascular Stents

The American College of Cardiology does not offer a recommendation for these services at this time, based on a low response rate for this survey.

AMERICAN COLLEGE OF CARDIOLOGY

Recommendations Concerning
Percutaneous Transluminal Coronary
Atherectomy, each additional vessel

CPT Code: 929XX

Descriptor: Percutaneous transluminal coronary atherectomy, any method, with or without balloon angioplasty; each additional vessel

Current HCFA Work RVU: none

Recommended Work RVU: 6.5 (650)

This completely new code for 1993 is an add-on to the initial vessel atherectomy. The response rate for this survey was 55.56 percent and resulted in a mean value of 1180 and a median of 650. As with balloon angioplasty, each additional vessel treated results in increases physician time, effort and stress.

Multivessel disease carries increased risk due to the frequent association of increased LV dysfunction in patients with multivessel disease and increased numbers of vessels exposed to atherectomy.

S:\E\R\ATHERPT.692

AMERICAN COLLEGE OF CARDIOLOGY

Recommendations Concerning Percutaneous Transluminal Coronary Atherectomy

CPT Code: 929XX

Descriptor: Percutaneous transluminal coronary atherectomy, any method, with or without balloon angioplasty; single vessel

Current HCFA Work RVU: none

Recommended Work RVU: 17.75 (1775)

This is a completely new code for 1993. The survey for this service had a response rate of 55.56 percent with a mean value of 1750 and a median of 1775. Our respondents were familiar with this procedure with frequency of performance in the past year ranging from 25 to 235 cases. This value is based on comparison to both the PTCA single vessel (RVU = 1500) and a left heart catheterization.

Procedure: Atherectomy, although not dissimilar from balloon angioplasty in that it is a method used to open blocked arteries, physically achieves its goal by actually removing the plaque from the vessel. The typical atherectomy is done particularly in proximal lesions where balloon angioplasty involves significantly higher risk. It more recently has been used in vessels of 2.5 to 3.0 mm in size. It is particularly good when there is an ulcerated lesion or high risk lesion with eccentricity. Atherectomy has the advantage of less incidence of acute closure. Increasingly, atherectomy is used in patients where balloon angioplasty has failed. In these patients especially, the procedure is significantly more time consuming than balloon angioplasty. In addition, patients who are rejected as candidates for balloon angioplasty are often referred for atherectomy. These patients are often more seriously ill than the typical angioplasty patient with a resulting higher complication rate.

The work in performing atherectomy is greater than that for balloon angioplasty due in part for the necessity of making multiple passes with the catheter to remove the plaque. Each pass of the catheter removes 5 to 7 specimens of wall plaque, and then the cutting device must be emptied. Each of these steps requires physician time and effort. Also, atherectomy requires two assistants in addition to the physician, whereas balloon angioplasty can be performed by a physician with one assistant.

ATTACHMENT 15

ASSOCIATED NEUROLOGISTS, P.C.
1459 JOHNSTON - WILLIS DRIVE
RICHMOND, VIRGINIA 23235

TELEPHONE (804) 323-1145

DIPLOMATES IN NEUROLOGY

NELSON G. RICHARDS, M.D.
CHILD/ADULT, EEG

JOHN J. HENNESSEY, IV, M.D.
ADULT, NEURO-OPHTHALMOLOGY, EMG

CONSULTATION OFFICE:

C/O BAY INTERNISTS
KILMARNOCK, VIRGINIA 22482

JUNE 23, 1999

TO: MARK SEGAL, PhD.
FROM: NELSON RICHARDS, M.D., AMERICAN ACADEMY NEUROLOGY
SUBJECT: NEW OR REVISED CPT CODES

OUR ADVISORY COMMITTEE HAS EVALUATED THE IDENTIFIED CODES WITH MEAN AND MEDIAN CALCULATIONS.
IN ADDITION THE Epilepsy CENTERS THROUGH MARE ASSOCIATES HAVE ALSO EVALUATED THE RVW.
ATTACHED ARE THE RVW FROM EACH AND A DESCRIPTION of THE PROCEDURES of physician WORK.

Tracking Number	CPT Code	CPT Descriptor	Type of Revision	Work RVUs (X 100) MEAN / MEDIAN	Global Period**	Key Reference Services in Priority Order	Typical Patient and Nature and Extent of Services Provided – Including any Special Assumptions You Made Rating the Service	About How Many Times in the Last 12 Months Have You Provided This Service?	If Zero, How Many Times Have you Provided the Service in Your Career?
264	95951	combined electroencephalographic (EEG) and video recording and interpretation, each ~~initial~~ 24 hours	Code 95951 modified to account for each 24 hour period rather than the initial 24 hours	900* / 425/510	XXX	99255	MD/OD STUDY of 24 hour VIDEO AND GRAPHICS		
266	959XX•	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG; electroencephalographic (EEG) recording and interpretation, each 24 hours	A new code added for monitoring for localization of cerebral seizure focus	500* / 344/375	XXX	99255 95951	AMBULATORY RECORDING of OUTPATIENT SEIZURE PATTERNS		
267	959XX•	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry; electroencephalographic (EEG) recording and interpretation, each 24 hours	A new code to be added for monitoring for localization of cerebral seizure focus	500* / 344/375	XXX	99255 95951	AMBULATORY RECORDING of IN PATIENT SEIZURE PATTERN		

* MARC ASSOCIATES

"A service paid on a global basis includes visits and other services provided in addition to the basic procedure during a specified number of days before and after the procedure is provided. The *global period* identified above refers to the number of preprocedural and postprocedural days of care that are included in the payment for a global surgical package as determined by the Health Care Financing Administration for Medicare payment purposes There are three categories of global services (090, 010, 000). In addition, there are two types of alpha global codes that may be used:
XXX = Global concept does not apply to the code; YYY = Global period is to be set by the Medicare carrier; ZZZ = Code is part of another service and falls within the global period for the other service.
Refer to Table 2 for the services included in each type of global package.

A "separate procedure" is one that is commonly carried out as an integral part of a total service and thus not generally identified separately. In those instances, however, when such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure."

Final assignments of codes and code descriptors are subject to change by the CPT Editorial Panel prior to publication of *CPT 1993*. The information contained in this questionnaire is confidential and proprietary and should only be used pursuant to participation in the AMA/Specialty Society RVS Update Process.

264 - Clinical Description of EEG and Video Recording - 95951

Intensive EEG/Video monitoring is widely accepted as a safe and clinically effective method for evaluating carefully selected patients with seizure disorders. In this technique, 16-128 channels of EEG are recorded continuously onto a magnetic or optical storage medium while the patient remains in front of a closed circuit television camera. There are several clinical indications for this: diagnosis, classification, localization and other reasons. For diagnosis, monitoring determines whether episodic spells are epileptic as opposed to non-epileptic. For classification, in patients suspected of having one or more epileptic seizure or both epileptic and psychogenic seizures, intensive EEG video monitoring can be helpful for separating the various types of spells to document their coexistence and to plan differential treatment. Monitoring can also occasionally provide the only source of information regarding which type of epileptic seizure occurs in an individual patient, which in turn can substantially influence choice of medications. For localization, localization of the seizure focus is of paramount importance for patients being considered for surgical treatment. Intensive EEG/Video monitoring is crucial to such localization issues.

In certain circumstances, intensive EEG/Video monitoring can occasionally be accomplished in an outpatient EEG/laboratory (if appropriate resuscitation equipment is available). However, this requires that a technologist must be available to keep the camera pointed to the patient, attend to the patient during epileptic seizures, correct technical problems as they occur, and observe the patient for occurrence of seizures which might go unreported by the patient. Especially with patients who have multiple complex partial seizures every day, intensive EEG/Video monitoring could be done in an outpatient EEG laboratory or in a similar well-controlled outpatient environment.

The number of steps involved and the complexity of the data obtained during EEG/Video monitoring differ significantly from that necessary for routine EEG monitoring typically used in an outpatient setting. The following activities require two to ten hours of highly skilled physician time per eight to twenty-four hours of reading.

A. Initial decisions must be made by the epileptologist once the patient is determined to require video/EEG monitoring. First, what montage, (ie. what arrangement of electrodes for recording purposes), is necessary? Many combinations are possible given the number of electrodes placed on the scalp. This decision is critical to obtain the maximum pertinent information. In addition, electrodes are placed to monitor muscle activity, the cardiac rhythm, eye movements, and respiration. In addition various invasive electrodes may be necessary including sphenoidal electrodes which since they are invasive and have certain risks associated with them must be inserted with great care after careful consideration. Reassessment of electrodes used must be done periodically during monitoring.

B. Specific steps must be taken to provoke a meaningful number of seizures in a reasonable amount of time in a manner that reduces the risk of injury to acceptable levels. The steps include decisions about medication reduction (requiring detailed knowledge of the pharmacology of the drugs involved), sleep deprivation, fasting, and exercise.

C. Supervision of technical personnel during the recording process must be performed in order to help EEG technicians as well as nursing personnel. The physician must show the technicians/nurses what to look for in terms of the specific events, in case of multiple events, know what number of each type of event to replay for review, and determine how often to perform provocative maneuvers such as hyperventilation and photic stimulation as well as to know how much baseline recording of sleep and wake time should be recorded.

D. A complete review of each particular video and EEG recording is the most time consuming and complex part of the sequence. The physician conducts a preliminary review of the data using the video monitor and scanning device. He/she then directs the technologist to print out selected samples for more detailed analysis including:

1. Review of EEG background activity in all states of wakefulness, drowsiness, and sleep as well as provocative maneuvers such as hyperventilation and photic stimulation;

2. Identification of suspected interictal epileptiform discharges with respect to whether or not they are artifact or genuine cerebral activity, their localization, and their significance with respect to other clinical features of the patient;

3. Review of the EEG activity correlated with the video record for seizure events, specifically looking at the number of events, classifying their type by EEG clinical criteria from the video record, correlating the onset of clinical seizure behavior with EEG changes, and deciding which events should be replayed with different filter settings or different montages. Finally a dictated report needs to be generated for the patient's medical record.

E. When monitoring is complete all of the patient's events from all the sessions must be reviewed at one time to determine any gradual change in events during the recording process to develop an overall impression. A final summary, describing the information obtained from all the events recorded with respect to similarity, classification and determination of

localized or multifocal onset of seizures is written. Finally, this data is collated with other clinical features for presentation to the family as well as to colleagues for determination of appropriateness for surgery or other treatment options.

Ambulatory Cassette Recorded EEG, each 24 hours - 95950
Recommended RVUs - 1.59
Technical Component - 3.0

Ambulatory cassette recorded EEG, typically using the 8 channel Oxford brand system, involves recording limited samples of EEG with a small portable recorder that is only slightly larger than a Walkman. The patient has many fewer electrodes placed than with a standard EEG. EEG is recorded on a cassette tape for 24 or more hours and each tape lasts for 24 hours. The patient usually goes home and engages in normal daily activities, writing down the time of any seizures or spells. Inpatient recordings can also be done with this devise. After recording, the cassette is scanned on a "reading device" and segments of EEG can be printed for more detailed study.

Ambulatory cassette recorded EEG is used primarily for differential diagnosis of spells that are possibly seizures despite non-diagnostic routine EEG. Ambulatory cassette recorded EEG during some seizures (focal sensory or motor) may be entirely normal; thus, for those problems video EEG monitoring is more appropriate. Ambulatory cassette recorded EEG is useful for counting seizure frequency in patients with obvious EEG changes. Medication changes can be assessed more quickly by counting seizures, particularly in patients with daily seizures.

It takes a technologist about 30 minutes to place electrodes and another 30 minutes to instruct the patient and complete the hookup. Reading the tape takes 1-2 hours of physician and technologist time depending on the number of events that need to be printed out. The physician should be fully trained and preferably board certified in neurology and clinical neurophysiology. OR PEER RECOGNIZED FURTHER TRAINING AND EXPERIENCE

2160 - Computerized Portable EEG with 16 or more Channels, each 24 hours - or 95 97 XX
Recommended RVUs - 5.0
Technical Component - 9.0

A new form of ambulatory monitoring has been developed that allows recording from 16 or more electrodes and, when indicated, sphenoidal electrodes as well. EKG and other physiological measurements are also possible in addition. Selective data storage makes it possible to obtain information from a relatively large number of electrodes, over periods of 24 hours or more. The storage mode is activated only at the time of seizure onset so that only the epileptic seizure and a short period of time before and after are retained in memory. Storage can be activated by the patient or an observer at the first indication of a seizure, or by a computerized seizure detecting system to automatically activate

storage each time an EEG ictal is recognized. As with routine ambulatory cassette recorded EEG, the patient carries a small recording device in a pouch and can move about at will. If the computerized seizure detector is used, however, this requires an additional piece of equipment slightly smaller than a six pack, which must be plugged into an electrical outlet. Consequently, the system is not truly ambulatory in this situation. It is, however, portable and can be readily used at home or in the workplace. It can also be used in an inpatient setting, in association with EEG/video recording, as with other forms of inpatient 24 hour monitoring.

Outpatient ambulatory computer recorded EEG monitoring with 16 or more channels usually does not involve video monitoring. As with standard ambulatory EEG, it can be used for differential diagnosis of epileptic seizures, for determining how often epileptic seizures are occurring, and whether there is a specific pattern that may influence treatment schedules or necessitate avoidance of specific precipitating factors. Unlike ambulatory cassette EEG, however, the larger number of electrodes makes it possible to use this system to determine what types of seizures might be occurring, and to localize the site of onset of partial seizures when respective surgical treatment is being considered. In some cases, outpatient ambulatory computer recorded EEG monitoring with 16 or more electrodes can be used as a screening test for surgical candidates, or for obtaining additional information after a brief period of inpatient long-term EEG monitoring with video recording. Video recording of a least a few seizures is usually necessary before definitive localization of seizure onset is obtained; however, outpatient ambulatory EEG with 16 or more channels can greatly reduce the time necessary for expensive inpatient long-term EEG monitoring.

Approximately one hour of a technologist's time is required to prepare a patient for ambulatory computer recorded EEG with 16 or more channels, and another 30 minutes to instruct the patient and/or family members in the use of the system. Usually the patient returns to the hospital every 24 hours to replace batteries and to unload data. This may take one or several hours of technologist time, depending on the number of seizures that have occurred.

An experienced physician clinical neurophysiologist must supervise and train technologists in the use of the ambulatory EEG equipment and the proper display of data. Each seizure must then be reviewed by this specialized physician, which again takes one or more hours a day, depending on the number of seizures that have been recorded. A review of the electrographic data may also involve computerized manipulation such as changing the time base or filtering out artifact.

OR HAVE RECOGNIZED PEER DOCUMENTATION AND BOARD ELIGIBILITY

The physician should be board certified in neurology and clinical neurophysiology, and should also have special training in long-term monitoring, including the use of the particular ambulatory EEG device, in order to interpret ictal recordings. In addition to EEG technologists, it is also necessary to have access to an electronics technician who is able to maintain and repair equipment, including the computers necessary for data display and storage.

267- Ambulatory (Cable or Radio, 16 or more channel) Telemetered EEG, each 24 hours, 959XX
Recommended RVUs - 5.0

Ambulatory radio or cable telemetered EEG provides all of the detail of a standard 16 channel computerized EEG recording. The service is provided in an outpatient clinic setting or while the patient is hospitalized. In either case, the patient is under direct nursing supervision when being monitored. Prolonged recordings have a much higher yield of useful clinical information than does a routine EEG. The data obtained is useful for localization for seizure surgery when supplemented by video EEG recordings. Recording are usually performed 24 hours a day.

One hour of technologist's time is needed to set up the equipment, apply the electrodes and instruct the patient. The technologist must be available to monitor EEG changes and be available to correct technical problems. Daily maintenance and review requires 1 or more hours of technician time each day.

An experienced physician clinical neurophysiologist must supervise and train technologists in the use of the ambulatory EEG equipment and the proper display of data. Each seizure must then be reviewed by this specialized physician, which again takes one or more hours a day, depending on the number of seizures that have been recorded. A review of the electrographic data may also involve computerized manipulation such as changing the time base or filtering out artifact.

OR ELIGIBLE AND HAVE PEER RECOGNIZED FURTHER TRAINING AND EXPERIENCE

The physician should be board certified in neurology and clinical neurophysiology, and should also have special training in long-term monitoring, including the use of the particular ambulatory EEG device, in order to interpret ictal recordings. In addition to EEG technologists, it is also necessary to have access to an electronics technician who is able to maintain and repair equipment, including the computers necessary for data display and storage.

SURVEY OF NEUROSURGEONS

	Strips	Depths	Grids
Memphis (Wyler)	90	0	2
Mayo	8	16	0
Montifiore	12	7	5
UCLA	0	9	6
Mincep (Maxwell)	2	2	20
Yale	34	34	11
Medical College of Georgia	0	22	3
Cleveland	12	12	40
Average (of those providing service)	27	15	12

SURVEY OF NEUROSURGEONS

	Strips	Depths	Grids
Memphis (Wyler)	90	0	2
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Medical College of Georgia	0	22	3
Cleveland	12	12	40
Average (of those providing service)	27	15	12

AMERICAN SOCIETY OF CLINICAL ONCOLOGY ASCO

435 North Michigan Ave. Suite 1717 Chicago, IL 60611-4067 312/644-0828 FAX: 312/644-8557 Executive Director James B. Gantenberg
750 17th St., N.W. Suite 1100 Washington, DC 20006 202/778-2396 FAX: 202/778-2330 Director, Government Relations, Stacey Beckhardt

MEMORANDUM

Via Telecopy

DATE: May 13, 1992

TO: Mark J. Segal, Ph.D.

FROM: Joseph S. Bailes, M.D. JB

RE: Physician Work Values – 96440, 96445, 96450

The following outlines the procedures utilized in and outcome of our efforts to assign physician work relative values to several revised chemotherapy codes. ASCO's standing Clinical Practice Committee served as our RVS Committee. No outside expertise was sought as it was felt that Committee members had sufficient expertise and familiarity with the procedures requiring evaluation. The Committee assessed relative values for three codes:

96440 chemotherapy administration into pleural cavity, requiring and including thoracentesis;

96445 chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis; and

96450 chemotherapy administration into CNS (e.g., intrathecal), requiring and including lumbar puncture.

Committee members were sent relevant materials prepared by AMA and asked to assign relative values. To avoid bias, we elected not to reveal relative values previously assigned to these codes. Work values were, however, provided for 85095, 62270, 49080, 85102, and 32000. Median relative values were calculated based on the mail survey.

Subsequently, a conference call was held to discuss the values. I coordinated this call as I serve as chair of ASCO's Clinical Practice Committee. Participants in the conference call were asked if they wished to revise their recommendations as a result of issues raised in the discussion and their knowledge of the median values from the mail survey. Several individuals did modify their proposed relative values. Inadequate consideration of risk associated with the procedures was the most common rationale for increasing relative values. Both before and after the conference call, however, there was considerable consistency with respect to the reference codes selected by participants. Following the call, new median values were calculated.

The attached tables provide RVU rankings from the mail survey and the conference call. Data are reported in rank order. As requested, we have computed medians as well as the 25th and 75th percentiles.

Assigning work values to these codes is relatively straightforward, since in each case the code encompasses a service for which a relative value is already established. That is, relative values exist for thoracentesis, peritoneocentesis, and lumbar puncture, and the relative value for the chemotherapy procedure can be assessed by estimating the additional work involved as a result of the chemotherapy.

It should be noted that the values developed by our committee are clearly more accurate that the existing values for these codes. For example, under the current values, chemotherapy requiring thoracentesis is valued less than the thoracentesis by itself. Comparisons involving the current values include:

CPT code		Current work value
96440	Chemo requiring thoracentesis	1.59
32000	Thoracentesis	1.63
96445	Chemo requiring peritoneocentesis	1.59
49080	Peritoneocentesis	1.42
96450	Chemo requiring lumbar puncture	1.27
62270	Diagnostic lumbar puncture	1.18
62289	Lumbar injection	1.73

In summary, based on the median values of the survey, ASCO recommends that the work values for the newly revised codes be established as follows:

96440	Chemo requiring thoracentesis	2.50
96445	Chemo requiring peritoneocentesis	2.31
96450	Chemo requiring lumbar puncture	2.00

If you have any questions regarding this presentation, please contact Stacey Bockhardt, ASCO's Director of Government Relations, at 202-778-2396.

Attachments

Society of Critical Care Medicine

March 24, 1992

VIA HAND DELIVERY

The Honorable Michael Hudson
Acting Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
Attention: BPD-712-P

Dear Mr. Hudson:

The Society of Critical Care Medicine ("the Society") appreciates the opportunity to comment on the "initial" relative value units ("RVUs") established in the Final Rule implementing the Medicare Fee Schedule. 56 Fed. Reg. 59502. The Society's comments focus exclusively on the significant coding and reimbursement inequities that exist concerning HCPCS critical care codes 99291 and 99292. These inequities threaten to impede the delivery of cost efficient, high quality care to Medicare beneficiaries. Therefore, the Society urges the Health Care Financing Administration to revise the definition and payment levels with the utmost haste.

Founded in 1970, the Society is committed to the improvement of care for patients who are critically ill or injured. Such patients often require prolonged attention, the evaluation and manipulation of multiple databases and advanced technology, and decisionmaking of the highest complexity -- at times on an around-the-clock basis.

Such services require separate and distinct evaluation and management codes with relative value units that accurately reflect the intensity and time required. The Society is particularly concerned because, to our knowledge, no physician

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who primarily practices critical care medicine was surveyed in the Hsiao study or participated in the development of the CPT definition of these services. Moreover, the proposed RVUs for these critical codes were not included in the Notice of Proposed Rulemaking for the Fee Schedule published on June 5, 1991. Thus, the Society was denied any opportunity to comment on these values before implementation of the Fee Schedule.

The Society urges HCFA to seriously consider the recommendations discussed in our comments. Without such changes to the definition and payment levels for critical care visits, the delivery of appropriate services will be seriously impaired and, in fact, Medicare costs will increase because of the greater utilization of consultants to deliver this care.

Respectfully submitted,

THE SOCIETY OF CRITICAL CARE MEDICINE

Frank B. Cerra

Frank B. Cerra. M.D., F.C.C.M.
President

Russell C. Raphaely

Russell C. Raphaely, M.D., F.C.C.M.
Chair, Healthcare Policy Division

8101 East Kaiser Boulevard
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(714) 282-6000

Of Counsel:

Stephan E. Lawton
Laura E. Loeb
HOGAN & HARTSON
555 13th Street, N.W.
Washington, D.C. 20004
(202) 637-8615

Society of Critical Care Medicine

COMMENTS OF THE SOCIETY OF CRITICAL CARE MEDICINE ON THE INITIAL RELATIVE VALUE UNITS OF THE MEDICARE FEE SCHEDULE

Reference:

File Code: BPD-712-P;
Medicare Program; Fee
Schedule for Physicians'
Services; Final Rule
56 Fed. Reg. 59502

March 24, 1992

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Critical care is cost efficient care, because the need for additional consultative visits is typically averted. This means a savings to Medicare of reimbursement for at least one Level 5 consultation with a work RVU of 3.03 for each critical care visit. Often more than one consultant is required if no physician is providing coordinated critical care, translating into a savings of perhaps two or three times the 3.03 RVU for Medicare or equaling 6.06 of 9.09 work RVUs.

While it is a difficult comparison to make, the Society believes the intensity of work involved in a 60-minute critical care visit perhaps most closely corresponds to the intraoperative work involved with some cardiac or neurosurgery. Recognizing that the intraoperative work during surgery involves more than the cognitive aspect of a critical care visit, it is instructive to note that the intraoperative work RVU for a coronary artery bypass (33516) for 60 minutes would be 3.82 (30.55 work RVUs X .50 (intraoperative work)/4 (procedure is normally 4 hours long)); for an ascending aorta graft (33860), the work RVU for 60 minutes would be 4.51 (36.09 X .50/4); or for the removal of a brain lesion the work RVU would be 4.25 (34.01 X .50/4).

In short, the Society believes that a work RVU for a 60-minute critical care visit with the exclusion of all procedures should more accurately be valued at around 4.0, if not higher, compared to other services requiring the same level of skill, intensity, and work.

being provided five (5) days later. This cognitive time should be reimbursed, and also demonstrates why procedures included in the critical care visit code are misleading and not reflective of the work performed.

In short, the use of critical care visit codes should not be limited by the day or by hospitalization, as per the example given. Moreover, critical care visits should not include any time during which procedures are performed.

III. Work RVUs for Codes 99291 and 99292 Must Be Revised.

The current physician work RVU for a 60-minute critical care visit -- code 99291 -- of 2.49 is inaccurate on its face, even when procedures are unbundled. [The corresponding value for code 99292, which is directly related to the value for 99291, also is undervalued.] The work RVU for the highest level of emergency room visit is 2.79. The critical care visit work RVU should be greater than that for emergency room visits for the following reasons:

- The highest level emergency room visit usually requires additional consultative care, whereas the critical care visit usually encompasses this type of specialized expertise.
- The highest level emergency room visit typically would not last as long as the hour used to define the critical care visit. Rather, normally the patient would be transferred to an ICU or operating room or perhaps would die.
- Typically, the decisionmaking is more complex for the critical care visit, requiring the distillation of multiple databases and the application of advanced technology to prevent or combat single or multiple vital organ system failure.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

97750

Tracking Number: AZ39 Global Period: XXX **Recommended RVW:** 0.60

CPT Descriptor: Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

The physician refers the patient, a data entry person, for evaluation and treatment of suspected carpal tunnel syndrome. Nerve conduction studies were negative, however patient complains of a numbness in the median nerve distribution and pain in the proximal palm while on the job and often at night. Assessments are made of pinch and grip strengths using computerized instruments which are calibrated before each evaluation. Sensibility tests of touch pressure threshold and vibration are also performed on the patient for their ability to detect early development of carpal tunnel syndrome. Computerized instruments are preferred as hand held instruments are subject to inter-rater reliability. Test results are negative, and work simulation is set-up for patient to perform key board entry for 30 minutes. Upon re-test, vibration detection, touch pressure threshold have decreased from normal to diminished light touch in the dominant hand. Pinch and grip strengths have also diminished because of pain. Conservative treatment is initiated which includes ergonomic changes in equipment and job pacing in conjunction with physician's application of anti-inflammatory medication.

Description of Pre-Service Work:

Chart reviews for medical treatment; pre set up of activities, equipment, area; review of previous documentation as needed; communicating with other health care professionals (eg, social worker, nurse); discussions with family members; calls to referring MD for additional information/clarification.

Description of Intra-Service Work:

Status check of patient's level of pain, sensation, pinch and grip strength, and functional job abilities is performed. Provider develops program to address instruction/practice of accommodated work related activities. Also educates patient to safe job performance, job pacing, and self-management of program. Further Intra-Service Work is detailed in the vignette.

Description of Post-Service Work:

Writing up report/documentation of treatment; calls to referring physician to report progress; communicating with other team members

KEY REFERENCE SERVICE(S):

CPT Code	CPT Descriptor	RVW
M0008	Office visit including combination of any modality(ies) and procedure(s), each additional 15 minutes	0.51
95860	Needle electromyography, one extremity and related paraspinal areas	0.97
97250	Myofascial release/soft tissue mobilization	0.45

RELATIONSHIP TO KEY REFERENCE SERVICE(S) AND/OR OTHER RATIONALE FOR RVW RECOMMENDATION (Include all applicable elements of work in rationale: time; technical skill & physical effort; mental effort and judgement; and stress):

Survey median adjusted downward given probability that those surveyed were relating this to use for evaluation coding. Maintains ranking as higher than direct procedural codes given probability of need for test interpretation, assessment, etc.. Maintains ranking as high than 15 minutes direct care where no testing is occurring. Ranks higher than Key Reference Code M0008, and lower than invasive 95860 which may have inherent greater patient risk.

IF RECOMMENDED RVW IS BASED ON AN ALTERNATIVE METHOD INSTEAD OF THE SURVEY RESULTS, PLEASE EXPLAIN WHY:

See Above Rationale

SURVEY DATA:

Organization: APTA

Median Intra-Service Time: 30 Low: 5 High: 360

Median Pre-Service Time: 10 Median Post-Service Time: 15

Length of Hospital Stay: _____ Number & Level of Post-Hospital Visits: _____

Number of Times Provided in Past 12 months (Median): 150

Other Data: _____

Sample Size: 97/300 Response Rate (%): 32.3 Median RVW: .75

25th Percentile RVW: .51 75th Percentile RVW: .90 Low: .25 High: 2.00

Please complete the following if more than one organization was involved in developing the recommendation:

Organization: AOTA

Median Intra-Service Time: 60 Low: 15 High: 180

Median Pre-Service Time: 15 Median Post-Service Time: 20

Length of Hospital Stay: _____ Number & Level of Post-Hospital Visits: _____

Number of Times Provided in Past 12 months (Median): 50

Other Data: _____

Sample Size: 180 Response Rate (%): 17.2 Median RVW: 1.02

25th Percentile RVW: .75 75th Percentile RVW: 1.3 Low: .39 High: 2.5