AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE MEETING

The Pointe Hilton Resort at Squaw Peak
Phoenix, Arizona
January 29-31, 1993

MINUTES

I. Call to Order

Doctor Rodkey opened the meeting at 8:07 a.m., Friday, January 29. The following RUC members and alternates were in attendance:

Grant V. Rodkey, MD, Chair
Larry Bedard, MD*
Robert Berenson, MD
Terence Beven, MD*
John O. Gage, MD
Timothy Gardner, MD*
Tracy R. Gordy, MD
Michael Graham, MD
Kay K. Hanley, MD*
W. Benson Harer, Jr., MD
James G. Hoehn, MD
Charles F. Koopmann, Jr., MD
George F. Kwass, MD
Michael D. Maves, MD
David L. McCaffree, MD
James M. Moorefield, MD
L. Charles Novak, MD
Eugene S. Ogrod, MD
Byron Pevehouse, MD
G. Thomas Pfaehler, MD*
William Rich, MD*
Gregory A. Slachta, MD
Ray E. Stowers, DO
John P. Tooker, MD*
Richard Tuck, MD
John Tudor, Jr., MD
David B. Troxel, MD*
Joe R. Wise, Jr., MD*
Michael Wolk, MD*
*RUC Alternate

II. Approval of November 20-21 Minutes

The committee discussed the use of methodologies that are different from the RUC's standard methodology for developing relative value recommendations. There was concern about whether a society would have to provide its methodology for approval by the Research Subcommittee prior to its use in developing recommendations. Members decided that the minutes were correct in stating that the society would have to provide its methodology for review and comment by the subcommittee (page 8). **They voted to approve the minutes as written.**

Doctor Rodkey expressed concern about the length and format of the two presentations at the November meeting. He suggested that future presentations should be time-limited. After the committee discussed the issue, Doctor Rodkey said there was a consensus that informational presentations must be given in a standard format that included an opportunity for questions. Further, the presentations should last no more than 15 minutes. He asked for a motion to that effect. **The proposal was moved, seconded, and adopted.**

III. Approval of January 10 Minutes

Doctor Rodkey said that approval of the January 10 minutes would also serve as approval of the RUC's letter commenting on HCFA's November 25, 1992, Final Rule. Doctor Tuck requested a change in the minutes to indicate that he had been unsure of the Academy's plans for commenting on the Rule. Further, the discussion of RUC assistance on issues related to adoption of the Medicare RVS by state Medicaid programs should not be considered an official request from the Academy. **The revised minutes were adopted.**

Discussion focused on a proposal to create a RUC subcommittee to consider pediatric issues in the adoption of the Medicare RVS for state Medicaid programs. Doctor Tuck informed the committee that Rep. Dan Rostenkowski has introduced legislation that would require HCFA to conduct a study to establish an RVS for pediatric services. The Academy would like the RUC to table its initiative pending the outcome of the Rostenkowski bill and to send a letter of support for the legislation. Doctor Wolk made the motion. The committee voted to table the subcommittee proposal but not to send a letter of support for the legislation.

Doctor Rodkey said that Dorothy Moss, of the AMA Washington Office, had requested some time on the RUC's agenda. Ms. Moss and Adrienne Lang, of the American Society of Anesthesiology, distributed baseball hats with the initials, RUC. Ms. Moss said that the RUC members had evolved into a cohesive group that represented the entire medical profession, not just their individual specialty societies, when they "put their RUC hats on."

IV. HCFA Update

Staff reported that the RUC's comments on the Final Notice containing the 1993 Medicare payment schedule were submitted to the Health Care Financing Administration January 22, and asked the specialty societies to send copies of their own comments to the AMA. The AMA will distribute the comments to the entire committee.

Barry Eisenberg reported that the AMA had sponsored an informational meeting for the Federation titled "Federation RBRVS Update" on January 27 in Chicago. Thomas R. Reardon, MD, of the AMA Board of Trustees, chaired the meeting, and Bart McCann, MD, from HCFA, and Doctor Rodkey participated on the panel. Eighty staff members from state medical associations, county medical societies, and national medical specialty societies attended. The presentations took place in the afternoon followed by a question-and-answer period. Mr. Eisenberg requested feedback from RUC members and specialty society staff who attended the meeting.

Doctor Marc Stone of HCFA reported that the comment period for the 1993 Medicare payment schedule had recently ended. HCFA received only 30 comments. He noted that the general reaction was positive. The negative comments focused on the 2.8% reduction in the RVUs. He described the protest against the change in values as a "tempest in a teapot" that resulted because people had become accustomed to a particular set of numbers and were confused by the change. He noted that "the scale is just as relative as it ever was."

Although a high percentage of the RUC's recommendations were adopted by HCFA, "it is incorrect to consider that as an endorsement of the RUC's process," Doctor Stone said. HCFA views the RUC as a "black box"; it bases its decisions on the credibility of the RUC's output, not the credibility of its internal methodology. "If the values seem plausible, we are willing to use them." He added that "we don't feel the RUC process has matured. It has not necessarily developed in a way that promotes the RVS as intended by the Hsiao study. There are institutional biases that work against it. We don't

have enormous confidence in it." Doctor Stone said that the letters from the primary care specialties to Doctor Todd prompted some of HCFA's concern.

A number of committee members and staff expressed their surprise and dismay upon hearing Doctor Stone's observations. Dorothy Moss asked him what level at HCFA he was representing. His response was that he was expressing the views of those who are in charge of evaluating the information that the RUC supplies to the agency. Barry Eisenberg echoed Ms. Moss' concerns. Sandy Sherman commented that the remarks appeared to contradict statements made by the HCFA administrator in correspondence, by Kathy Buto in a public meeting of the PPRC, and in previous meetings between AMA and HCFA staff. Doctor Bedard proposed a motion that the RUC formally request that HCFA provide a detailed written response explaining why the agency lacked confidence in the RUC process and why it thought that the RUC had an institutional bias. The letter would also ask HCFA for suggestions as to what would make the process more effective in the agency's view. There was considerable discussion about the relative merits of sending a letter versus meeting with HCFA in person. **As a result of the discussion, the committee passed an amended motion to prepare a letter that would be delivered in person by a small delegation. In an executive session on Saturday, however, the committee voted to rescind the motion.**

V. AMA Staff Report on Meeting with Physician Payment Review Commission Staff

Sandy Sherman reported that she and Dorothy Moss met with Physician Payment Review Commission (PPRC) staff to help them understand the RUC. PPRC Deputy Executive Director Lauren LeRoy expressed considerable interest in the RUC's process and methods. She was particularly interested in mechanisms to assure fairness and openness. The meeting was considered a very productive one. The AMA staff will continue to inform the PPRC about the RUC as the process continues to evolve.

VI. Update on CPT Editorial Panel

Doctor Gordy reported that the CPT Editorial Panel was scheduled to meet February 4-7. After the February meeting, the Editorial Panel will have one more meeting for CPT 1994 on April 15-18. At the conclusion of the current RUC meeting, the RUC will have acted on almost all of the codes that CPT had adopted in August and October.

VII. Calendar of Meeting Dates

The committee scheduled the next meeting of the Research Subcommittee for Saturday, March 6, in Chicago. The next full RUC meeting is April 30 - May 2 in Chicago.

VIII. Standard Methodological Requirements for Specialties

At the RUC's request, staff developed standard requirements that specialty societies would need to meet in preparing relative value recommendations for the RUC. During the committee's discussion, a key concern was whether physicians who participate in a survey are all thinking about the same procedure, especially in the absence of vignettes. Doctor Tudor moved that the RUC require specialty society RVS committees be required to develop vignettes so that physicians are surveyed based on the typical service and patient for the code. If more than one specialty society is involved in developing a consensus recommendation, they should use a common vignette in their survey. **The motion passed. A motion to accept the standard requirements, as amended, also passed.**

IX. Legal Issues: Recommended Guidelines for Compliance with Antitrust Law

Edward Hirshfeld, JD, presented "Recommended Guidelines for Compliance with Antitrust Law." The RUC had requested the document at its November meeting, with the intent that it be distributed to the Advisory Committee. Mr. Hirshfeld said that the federal government views physician groups that gather to discuss prices as inherently suspicious. The RUC, however, is not involved in pricing fixing or restraint of trade, so it is not in violation of antitrust laws. Mr. Hirshfeld emphasized that the RUC fits the model of a group involved in "standard-setting," and the importance of the RUC's continuing to act in a manner consistent with the Noerr-Pennington exemptions for such activities. It was moved that the committee strike the phrase "to all whose interests are affected" in bullet 1, page 3. The motion was withdrawn, however, and replaced with a motion to accept the document and distribute it to the specialty societies for comment. The RUC also asked Mr. Hirshfeld to consider the members' comments when he revised the guidelines. **The new motion was adopted.**

X. AMA Board of Trustees Report O

The reference committee of the House of Delegates had requested that AMA Board of Trustees Report O (I-92), "RVS Updating: Status Report and Future Plans," adopted by the House at the 1992 Interim Meeting, be provided to the RUC for information. Doctor Rodkey noted that during his meeting with the Board, the Trustees commended the RUC for its work. He said he told the Board that "the RUC members free themselves of parochial interests and represent the medical profession as a whole."

XI. Letter of January 6th to James S. Todd, MD, from John R. Ball, MD (ACP); Alan R. Nelson, MD (ASIM); Robert Graham, MD (AAFP); and James E. Strain, MD (AAP)

Doctor Rodkey invited the committee to discuss the recent correspondence between four primary care societies and Doctor Todd. Doctor Tudor noted that Doctor Todd's statements on the issue of the RUC as a model for negotiations under health system reform was responsive to the societies' concerns. He said that a number of procedural issues had been clarified in the last several months.

XII. Relative Value Recommendations (See Attachment A)

1. Magnetic Resonance Angiography

Tracking numbers: I1 through I7
Presentation: Robert L. Vogelzang, MD
Society of Cardiovascular and Interventional Radiology
William Bradley, MD
American College of Radiology
C. Leon Partain, MD
Association of University Radiologists
Bruce Sigsby, MD
American Academy of Neurology

Representatives of SCVIR, ACR, and AAN made a presentation on their consensus recommendations. Doctor Bradley provided an extensive explanation of the pre, intra, and post-service time, effort, and technical skill involved in magnetic resonance angiography (MRA).

Doctor Kwass observed that the consensus recommendations for MRA were valued only 10% higher than MRI even though Doctor Bradley's presentation indicated MRA may take more than twice as much physician time as MRI, as well as more intense judgment and a higher level of sophistication. He commented that it appeared that either MRA would be undervalued or that MRI was grossly overvalued. Doctor Vogelzang said that the survey, which used MRI as a reference, indicated that MRA was indeed more labor intensive. MRA was valued higher than MRI because the former requires more supervision, acquisition and reconstruction time. There was also considerable discussion about the amount of physician time and work involved in the service versus that of technicians when the physician is not present. Doctor Bradley indicated that the physician must be actually sitting at the console about 50% of the time.

Several RUC members also asked the presenters to explain when they would use MRA alone and when it might be used in addition to other techniques. Doctor Gage asked how the work of MRA compares with that of catheter angiography study. Doctor Bradley further noted that radiologists are confident in MRA as 80% of these services require no further study.

The discussion on this point gave rise to the issue of whether MRA should still be considered experimental, and whether it is a covered service. Doctor Gordy commented that arguments exist on both sides of this issue. The CPT Editorial Panel magnetic resonance angiography adopted the codes based on their understanding that it is no longer experimental. It became clear that HCFA would still have to make a coverage decision on these codes.

The question was also raised of why and how the consensus recommendations were developed using the results from the different surveys. Doctor Vogelzang said the SCVIR and ACR recommendations had been averaged because the experience of the two groups was comparable and their ratings should be equally weighted.

The consensus recommendations were adopted by a two-thirds majority.

Following the vote, Sandy Sherman asked Doctor Vogelzang to compare his experience using the RUC's revised survey instrument with the survey instrument used in the RUC's first cycle. Doctor

Vogelzang replied that the revised questionnaire was easier to use, that it had worked "pretty well," and that they had obtained a better response rate with it.

2. Stomach Excisions

Tracking number: *K1 through K5*
Presentation: *Paul E. Collicott, MD*
American College of Surgeons

Doctor Collicott presented the ACS and the American Osteopathic Association's consensus recommendations on stomach excision codes.

According to the ACS survey data, the follow-up care that is required for local excision of a malignant tumor of the stomach is more demanding than follow-up care for CPT code 43610 due to the malignant nature of the disease. More postoperative visits are required, as well as time to counsel the patient and family members. Moreover, the surgeon usually is involved in arranging for chemotherapy and/or radiation therapy for the patient. The AOA originally placed less value on the follow-up time and recommended a lower level code for office visits.

The RUC expressed concern that the specialty societies did not identify CPT code 43610 as a key reference service. There was considerable discussion about the possibility that, if the RUC were to recommend increased values for revised codes, specialty societies might inappropriately use the CPT and RUC processes to increase relative values for codes considered to be undervalued.

By ballot vote, the RUC rejected the ACS and AOA recommendations.

Doctor Rodkey, as chair, decided to refer the recommendations back to the societies for reconsideration.

3. Vulvectomy

Tracking number: *B1*
Presentation: *Larry P. Griffin, MD*
American College of Obstetrics and Gynecology

Doctor Griffin summarized ACOG's recommendation for vulvectomy.

ACOG recommended that 56XXX should be assigned RVW equal to the RVW for 56631: *Vulvectomy, radical partial; with unilateral inguinofemoral lymphadenectomy* (15.55) plus the increment of work between 56630: *Vulvectomy, radical partial* and 56631 (3.82). 56XXX is a bilateral procedure, therefore, a second incision is made to perform the inguinofemoral lyphadenectomy on the other side of the groin.

The ACOG recommendation was adopted by a two-thirds majority.

4. Artificial Insemination

Tracking number: *J1, J2, and J3*
Presentation: *Larry P. Griffin, MD*
American College of Obstetrics and Gynecology

ACOG recommends that the RVW for 5XXX1 (J1): artificial insemination; intra-cervical remain the same as the coding change was editorial only. ACOG recommended a higher value for 5XXX2 (J2): *artificial insemination; intrauterine* as it is more difficult than *artificial insemination; intracervical* (J1) because of the greater skill required for traversing the cervical canal and risk to the patient of anaphylaxis, infection, and perforation.

ACOG's recommendation equates the work involved in sperm washing with the work required for the lowest level office visit with a new patient. Sperm washing is always performed in conjunction with intrauterine artificial insemination and may also be performed in conjunction with intracervical artificial insemination. Sperm washing may be performed by a physician or limited license practitioner. A lengthy discussion followed Doctor Griffin's comments regarding work involved in this service and question of who most typically performs the service.

The ACOG recommendations for J1 and J2 were adopted by a two-thirds majority. A facilitation committee was appointed to review J3.

Doctor Rodkey appointed Doctors Bedard and Stowers to a facilitation committee to be chaired by Doctor Tudor.

On Sunday, Doctor Tudor reported on the facilitation committee meeting that took place on Saturday. The committee concluded that sperm washing does involve physician work both direct and supervisory. The facilitation committee recommended a relative value of 0.3 which represents the average of the work involved in Level 1 office visits for a new and an established patient. Doctor Griffin agreed with the facilitation committee's recommendation.

The facilitation committee recommendation for J3 was adopted by a two-thirds majority.

5. Skull Base Surgery

Tracking number: *A1 through A28*
Presentation: *Robert E. Florin, MD*
American Association of Neurological Surgery
Charles Koopman, MD
American Academy of Otolaryngology--Head and Neck Surgery
John Leonetti, MD
North American Skull Base Society
Jeffrey Resnick, MD
American Society of Plastic and Reconstructive Surgery

Doctor Florin provided an overview of the full set of codes, explaining that the new skull base surgery codes encompass "marathon operations" used to remove tumors from the base of the skull. These services are summarized as approach, definitive, and reconstructive procedures.

Sandy Sherman indicated that development of the skull base surgery consensus recommendations involved six different societies on the RUC's Advisory Committee, as well as the North American Skull Base Society, that began working this issue in October. She also indicated that the reference sets developed by each participant had been shared with the others, and that every effort had been made to facilitate coordination. Several representatives from neurosurgery, otolaryngology, and plastic surgery had been meeting for the two days preceeding the RUC meeting to discuss their survey results and develop consensus recommendations.

Doctor Leonetti responded to a question regarding the team approach to pre-, intra-, and post-operative work involved for a typical patient, providing an example of a recent case history and how the procedures would be coded. He noted that these procedures are rare enough that they do not lend themselves to vignettes describing "typical" services and patients. Doctor Koopman explained that each surgeon would provide pre-, intra-, and post-operative care in the ICU; the post-operative care would not be done by one member of the team alone.

Doctor Pevehouse commented that this new section in CPT attempts to organize the skull base surgery services and eliminate the building block approach to billing that created enormous bills and bewildered insurance companies. The codes would also tend to separate what the otolaryngologist would do from what the neurosurgeon would generally do. As surgeons developed more experience with these procedures, he said we might get to a point that a single surgeon would do both the approach and the definitive procedure, at which point the multiple surgery rule would apply and the overall payment would be further reduced.

Doctor Resnick pointed out that different specialties see different patients and the types of tumors may be less aggressive. For example, most tumors that plastic surgeons see are cutaneous, while neurosurgeon see patients with much more difficult approaches. There was also considerable discussion of the methodologies used to develop the consensus recommendations using the data obtained from the surveys. Doctors Florin and Koopman indicated that they had used the survey data as a starting point but had refined these data in the small group discussion process and had additionally used all the approaches outlined in the RUC's Instructions to Specialty Societies, including the "building block" approach and "valuing the increment," in attempting to identify the best value for each code as well as a rational set of values for the family of codes.

Doctors Stone and Ogrod commented on the wide range of values received during the survey process, and there was considerable discussion of whether the survey respondents understood that each procedure should be separately rated as to only the work involved in that procedure. There was also a great deal of discussion on the add-on codes for ligation of the carotid artery. Doctor Leonetti explained that these codes do not describe a procedure as simple as tying off a healthy artery because it is a pathological vessel affected by tumor, and it might take 3-5 attempts to get the suture around the vessel.

In discussing each code, the presenters were asked to compare the pre-, intra-, and post-service work of the new codes to the key reference procedures identified on the surveys, as well as to procedures done by other surgeons, such as a Whipple (code 48150). Other questions raised throughout the extensive discussion on these codes focused on the team approach, current coding for these procedures, pre- and post-operative care, how the various specialties reached agreement on RVW recommendations, and the savings that would result from having single codes for such complicated, multi-specialty procedures.

After 3-1/2 hours of discussion and balloting, the RUC accepted the 28 consensus recommendations (of the 28 codes, 11 were adopted unanimously).

Doctors Rodkey and Hanley complimented the presenters on their thorough presentations and noted that it would be difficult to exceed the quality of this presentation. Doctor Florin expressed his thanks to the North American Skull Base Society and to the experts who travelled great distances to help out with the process, specifically, Harry Van Loveran, MD and David W. Wright, MD. Sandy Sherman commented that this process served as a demonstration of the value of the November revisions to the survey instrument. In the societies' consensus process, they had to consider the weight that should be given to society's survey for each code, the reliability of the survey data, the incremental differences in work and payment policies, and the rationality of the values assigned to the codes as a group.

Doctor Graham asked if skull base surgery was a new procedure or new technology. Doctor Leonetti responded that it was both. Anatomy and pathology has not changed, however, the concept of team skull base surgery provides a solution to treating patients that would otherwise be considered inoperable. Doctor Stone indicated that as skull base surgery is a low volume procedure, the budgetary considerations would be small and not worth considering.

Doctor Graham moved that the RUC inform HCFA that it considers the skull base surgery codes as representing new procedures with an expansion of physician work. As such, payment for the services should not be limited under budget neutrality provisions. **The motion was seconded and passed.**

XIII. Reconsideration: Transtracheal Oxygen Administration.

William Dasher, MD, American College of Chest Physicians, said the College would like to survey its members, meet with the American Thoracic Society, and recommend a new value. The College did not participate in the original survey because it had not yet named an advisor. HCFA already has accepted the RUC recommendation that the service be valued at 3.0 RVUs. Doctor Kwass offered a motion to reconsider the earlier RUC recommendation. Doctor Pevehouse offered a substitute motion that the RUC staff assist the College in conducting a survey. If the survey results are significant, the College can ask the RUC to reconsider its recommendation. The RUC will decide whether to reconsider its recommendation after it sees the new survey data. **The committee adopted the substitute resolution.**

XIV. Review of Potential Cross-Specialty Reference List.

The RUC considered the list of reference services that specialty societies had proposed as candidates for the cross-specialty reference service list. Each specialty society on the Advisory Committee had been asked to send 20 - 25 proposed reference services for the RUC to consider. The resulting list consisted of about 600 services. The RUC members discussed and then rated the appropriateness of a sample of the proposed reference services from one to four (Attachment B).

The RUC advisors who attended the meeting were also invited to participate in the discussion. Sridhar V. Vasudevan, MD, alternate for the American Academy of Pain Medicine, said that only physicians who are trained in pain medicine should be able to use the pain medicine codes. He also said that evaluation and management codes should be based on time. Norman Hertzer, MD,

Advisory for the Society for Vascular Surgery, discussed each of the Society's proposed reference services.

At the conclusion of the rating process, Doctor Rodkey asked if any of the RUC members had comments on it. Several members said they felt the rating process had proceeded too quickly for them to make good decisions. Doctor Troxel suggested that the members should be able to mark their votes on the same sheet of paper as the proposed reference services. Doctor Hoehn said that the committee needed to rate only one code per each family of codes, preferably the initial code. Doctor Rich said he preferred to rate the codes in numeric order, rather than skipping around the list. Doctor McCaffree said he would like to postpone rating the 17000 series of codes until the next RUC meeting, when the American Academy of Dermatology will give a presentation.

XV. Other Issues: Developing RVW Recommendations for Revised CPT Codes.

Sandy Sherman asked whether the RUC wanted to change its Instructions to Specialty Societies on developing recommendations for revised CPT codes, as compared to new CPT codes, based on the committee's response to the ACS recommendations that were referred back to the society. She noted that she had attended a meeting of the ACS RVS committee to explain the RUC's instructions and that they had followed them as currently written. She indicated the committee might want to consider developing special methodological requirements for specialty societies dealing with revised codes and that these requirements could be discussed at the March 6 Research Subcommittee meeting.

Doctor Pevehouse proposed a motion that, when a specialty society presents a recommendation to the RUC for a revised CPT code that has an existing, published physician work value, it cannot change the work value unless (1) it presents a rationale for doing so and (2) the committee accepts the rationale. **By a count of hands, the motion passed, and the RUC indicated that this statement should be inserted in its Instructions to Specialty Societies.**

Doctor Ogrod expressed concern that the RUC had a "long-standing problem" of making policy under rushed circumstances. Doctor Hoehn asked that the staff provide a notebook of existing RUC policies. There was a discussion about dedicating a special meeting or an agenda item to consider procedural questions. A decision was made to devote a half day of a regularly scheduled meeting to procedural issues.

XVI. Adjournment.

Noting that a number of RUC members had left the meeting to catch their planes, Doctor Rodkey said that the session had come to an end. He expressed his appreciation to the RUC members, specialty society, and the RUC staff.
The meeting adjourned at 12:30 p.m.

ATTACHMENT A

RVW RECOMMENDATIONS ADOPTED AT THE JANUARY 29-31 RUC MEETING

Issue	TN	CPT Code	CPT Descriptor	Global Period	Specialty Society(s)	RVW Adopted
A Skull Base Surgery	A1	61X01	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration	090	ASPRS/AANS/AAO-HNS	29.60
	A2	61X02	Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy	090	ASPRS/AANS/AAO-HNS	33.60
	A3	61X03	Craniofacial approach to anterior cranial fossa; extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior cranial fossa	090	ASPRS/AANS/AAO-HNS	30.50
	A4	61X04	Craniofacial approach to anterior cranial fossa; intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa	090	AANS/AAO-HNS	34.80
	A5	61X05	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); without orbital exenteration	090	ASPRS/AANS/AAO-HNS	33.70
	A6	61X06	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s); with orbital exenteration	090	ASPRS/AANS/AAO-HNS	37.70
	A7	61X07	Infratemporal pre-auricular approach to middle cranial fossa (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with or without disarticulation of the mandible including parotidectomy, craniotomy, decompression and/or mobilization of the facial nerve and/or petrous carotid artery	090	AANS/AAO-HNS	41.00
A Skull Base Surgery	A8	61X08	Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery	090	AANS/AAO-HNS	43.00
	A9	61X09	Orbitocranial zygomatic approach to	090	AANS/AAO-HNS	39.00

Issue	TN	CPT Code	CPT Descriptor	Global Period	Specialty Society(s)	RVW Adopted
			middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra or intradural elevation of temporal lobe			
	A10	61X10	Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mas-toidectomy, decompression of sig-moid sinus and/or facial nerve with or without mobilization	090	ASPRS/AANS/AAO-HNS	28.80
	A11	61X11	Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including laby-rinthectomy, decompression with or without mobilization of facial nerve and/or petrous carotid artery	090	ASPRS/AANS/AAO-HNS	35.00
	A12	61X12	Transcondylar (far lateral) approayh to posterior cranial fossa, jugular foramen or midline skull base, including occipital condylectomy, mastoidectomy, resection of C1-3 verterbral body(s), decompression of vertebral artery with or without mobilization	090	AANS/AAO-HNS	37.00
	A13	61X13	Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	090	AANS/AAO-HNS	32.60
	A14	61X14	Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; extradural	090	ASPRS/AANS/AAO-HNS	25.00
	A15	61X15	Resection or excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa; intradural, including dural repair, with or without graft	090	ASPRS/AANS/AAO-HNS	26.80
	A16	61X16	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural	090	ASPRS/AANS/AAO-HNS	28.30
A Skull Base Surgery	A17	61X17	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; intradural, including dural repair, with or without graft	090	AANS/AAO-HNS	37.90
	A18	61X18	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural	090	AANS/AAO-HNS	35.40
	A19	61X19	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base;	090	AANS/AAO-HNS	41.20

Issue	TN	CPT Code	CPT Descriptor	Global Period	Specialty Society(s)	RVW Adopted
			intradural, including dural repair, with or without graft			
	A20	61X20	Transection or ligation, carotid artery in cavernous sinus; without repair	ZZZ	AANS/AAO-HNS	10.00
	A21	61X21	Transection or ligation, carotid artery in cavernous sinus; with repair by anastomosis or graft	ZZZ	AANS/AAO-HNS	35.00
	A22	61X22	Transection or ligation, carotid artery in petrous canal; without repair	ZZZ	AANS/AAO-HNS	7.50
	A23	61X23	Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft	ZZZ	AANS/AAO-HNS	33.00
	A24	61X24	Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus	090	AANS	40.40
	A25	61X25	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 verterbral bodies; extradural	090	AANS/AAO-HNS	31.10
	A26	61X26	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 verterbral bodies; intradural, including dural repair, with or without graft	090	AANS/AAO-HNS	42.30
	A27	61X27	Secondary repair of dura for CSF leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft (eg, pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)	090	ASPRS/AANS/AAO-HNS	16.00
A Skull Base Surgery	A28	61X28	Secondary repair of dura for CSF leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalized vascularized pedicle graft or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)	090	ASPRS/AANS/AAO-HNS	20.00
B Vulvectomy	B1	566XX	Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy	090	ACOG	19.37
I Magnetic Resonance Angiography	I1	7054X	Magnetic resonance angiography, head and/or neck, with or without contrast material(s)	XXX	AAN/ACR/SCVIR	1.85
	I2	7155X	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)	XXX	ACR/SCVIR	1.85
	I3	7215X	Magnetic resonance angiography,	XXX	AAN/ACR/SCVIR	1.84

Issue	TN	CPT Code	CPT Descriptor	Global Period	Specialty Society(s)	RVW Adopted
			spinal canal and contents, with or without contrast material(s)			
	I4	7219X	Magnetic resonance angiography, pelvis, with or without contrast material(s)	XXX	ACR/SCVIR	1.79
	I5	7322X	Magnetic resonance angiography, upper extremity, with or without contrast material(s)	XXX	ACR/SCVIR	1.77
	I6	7372X	Magnetic resonance angiography, lower extremity, with or without contrast material(s)	XXX	ACR/SCVIR	1.86
	I7	7418X	Magnetic resonance angiography, abdomen, with or without contrast material(s)	XXX	ACR/SCVIR	1.84
J Artificial Insemination	J1	5XXX1	Artificial insemination; intra-cervical	000	ACOG	0.94
	J2	5XXX2	Artificial insemination; intra-uterine	000	ACOG	1.12
	J3	5XXX3	Sperm washing for artificial insemination	000	ACOG	0.30

ATTACHMENT B

LIST OF PROPOSED CROSS-SPECIALTY REFERENCE SERVICES
RATED AT THE JANUARY RUC MEETING

10060	63047
11040	71010
15732	71020
17000	72170
17100	88300
17101	88304
17102	88305
27880	90843
33566	93010
34201	93224
35081	93320
35082	94010
35091	97128
35301	99201
35454	99203
35556	99211
35646	99212
35654	99213
35656	99214
36000	99231
36600	99232
38720	99238
45330	99263
60245	99273
62223	99282
62270	99263-21
63030	