

CMS-1429-FC-41

Submitter: Dr. Wayne Koch

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Organization: American Head and Neck Society

Category: Health Care Professional or Association

Issue Areas/Comments GENERAL

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

See Attachments: 0-AHNS Cover (CMS1429-FC) AHNS Attach A AHNS Attach B1 Maxillectomy AHNS Attach B2 Laryngectomy AHNS Attach B3 Lymphadenectomy AHNS Attach B4 Glossectomy AHNS Attach B5 Palatectomy AHNS Attach B6 Resect Tonsil AHNS Attach B7 Pharyngectomy CMS-1429-FC-41-Attach-1.DOC CMS-1429-FC-41-Attach-2.DOC CMS-1429-FC-41-Attach-3.DOC CMS-1429-FC-41-Attach-4.DOC CMS-1429-FC-41-Attach-5.DOC CMS-1429-FC-41-Attach-6.DOC

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December 29, 2004

The Honorable Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20001

RE: CMS 1429-FC: (Five Year Refinement of Work Relative Value Units)

Dear Dr. McClellan:

On behalf of the members of the American Head and Neck Society (AHNS), the following comments are submitted in response to the Final Rule published in the Federal Register on November 15, 2004. Specifically, these comments address the five-year review of work relative value units (RVWs) as specified on page 66372 of the Final Rule. The AHNS is the single largest organization in North America specifically focused on the advancement of research and education in head and neck oncology. Our membership includes Otolaryngologists, General Surgeons and Plastic Surgeons. Our purpose is to exchange and advance the scientific knowledge relevant to the surgery of head and neck tumors (exclusive of brain surgery) with an emphasis on cancer of the head and neck, and to facilitate and advance knowledge relevant to surgical treatment of diseases of the head and neck, including reconstruction and rehabilitation.

To identify head and neck surgery (HNS) codes that may be misvalued, we compared various physician work elements (pre-, intra-, and post-time; number of visits in the global period; and intensity) of HNS codes and a significant number of other codes that have been reviewed by the AMA RUC. Based on this review, we have identified 30 codes that we believe are misvalued. A list of these codes, with their current MFS RVWs and recommended RVWs, is included in Attachment A.

Attachments B1-B7 organizes the 30 misvalued codes into seven "families." Each Attachment Presents:

- 1) A discussion of why we maintain that the codes are misvalued, including inter- and intra-family anomalies and information about previous reviews, as appropriate.
- 2) A table that presents the current RVW, time and visit patterns, and IWP/UT for the misvalued HNS codes and many RUC-reviewed codes with similar time and visit patterns.
- 3) A clinical comparison of the misvalued HNS codes with one or more "reference" code(s).
- 4) A typical patient vignette for each misvalued HNS code.

Although we are not submitting a significant number of codes, and most of these codes have very low frequencies, these are the procedures that AHNS members perform and they should be fairly represented in the Medicare fee schedule. If the proposed recommendations in Attachment A were accepted without further review, the total impact prior to any budget neutrality adjustments would be 76,160 work RVUs. In terms of reimbursement, this represents approximately 2.8 million dollars (based on 2003 utilization and the 2005 conversion factor).

The AHNS does not have its own representation at the AMA RUC. Our previous exposure to the RUC process has been indirect (through other societies) particularly with respect to coding changes over the years. We hope that if CMS chooses to use the services of the RUC for the current review of physician work, that the Agency ask the RUC to include AHNS on all correspondence for their process. If you have any questions, please contact Dr. Wayne Koch at Department of Otolaryngology-Head and Neck Surgery, Johns Hopkins Medical Institutions, 601 N. Caroline Street, RM 6221, Baltimore, MD 21287, ph 410-955-4906, fx 410-955-0035, email: wkoch@jhmi.edu.

We thank CMS for considering our proposal to correct the misvaluation and rank order anomalies of our codes.

Sincerely yours,

Patrick J. Gullane, MD

Patrick J. Gullane, MD

President, American Head and Neck Society

Word Document Attachments:

AHNS Attach A

AHNS Attach B1 Maxillectomy

AHNS Attach B2 Laryngectomy

AHNS Attach B3 Lymphadenectomy

AHNS Attach B4 Glossectomy

AHNS Attach B5 Palatotomy

AHNS Attach B6 Resect Tonsil

AHNS Attach B7 Pharyngectomy

The table below presents 30 codes, organized into seven families, that AHNS has identified as misvalued. The 2005 MFS RVWs and the AHNS recommended RVWs are shown in Column D. The AHNS recommendations are the result of a calculation using the building block methodology (BBM), where the intensity of intra-work per unit time (IWPUT) is based on a specialty survey and consensus panel estimate of relative intensity (range = 0.06 to 0.09). Intra-operative minutes are based on surveys and a review of operative logs. Length of stay (LOS) is based on survey and review of patient records. Office visits (OV) and immediate pre- and post-times (not shown) are based on survey and consensus panel estimates. The AHNS submits that the application of the BBM in this fashion produces more precise results within and between families of similar codes than a survey of magnitude estimation. The IWPUT range of 0.06 to 0.09 is well within the median range of most surgical procedures that have been reviewed by the RUC and relative to CMS established IWPUTs for E/M services (0.031) and ICU care (0.067).

A	B	C	D	E	F	G	H
CPT	Long Descriptor	Source	RVW	IWPUT	INTRA Min	LOS	OV
Family 1-MAXILECTOMY							
31225	Maxillectomy; without orbital exenteration	RUC	19.20	0.04	180	8.0	6.0
		AHNS	23.33	0.08	180	6.0	5.0
31230	Maxillectomy; with orbital exenteration (en bloc)	Hvd	21.91	0.04	237	10.0	5.5
		AHNS	26.50	0.07	235	6.0	5.0
Family 2-LARYNGECTOMY							
31360	Laryngectomy; total, without radical neck dissection	Hvd	17.05	0.04	139	10.0	4.0
		AHNS	24.44	0.07	190	8.0	6.0
31365	Laryngectomy; total, with radical neck dissection	Hvd	24.12	0.05	258	8.0	6.0
		AHNS	34.40	0.08	300	8.0	6.0
31367	Laryngectomy; subtotal supraglottic, without radical neck dissection	Hvd	21.83	0.03	179	17.0	4.5
		AHNS	24.61	0.07	180	8.0	6.0
31368	Laryngectomy; subtotal supraglottic, with radical neck dissection	Hvd	27.05	0.02	307	20.0	5.5
		AHNS	32.34	0.08	260	8.0	6.0
31370	Partial laryngectomy (hemilaryngectomy); horizontal	Hvd	21.35	0.02	177	17.0	4.5
		AHNS	22.82	0.07	180	7.0	5.0
31375	Partial laryngectomy (hemilaryngectomy); laterovertical	Hvd	20.18	0.06	160	10.5	4.0
		AHNS	23.93	0.07	180	8.0	5.0

A	B	C	D	E	F	G	H
CPT	Long Descriptor	Source	RVW	IWPUT	INTRA Min	LOS	OV
31380	Partial laryngectomy (hemilaryngectomy); anterovertical	Hvd	20.18	0.06	163	10.5	4.0
		AHNS	24.11	0.07	180	8.0	5.0
31382	Partial laryngectomy (hemilaryngectomy); antero-latero-vertical	Hvd	20.49	0.04	200	11.0	4.5
		AHNS	24.31	0.07	180	8.0	5.0
31390	Pharyngolaryngectomy, with radical neck dissection; without reconstruction	RUC	27.49	0.03	300	13.0	6.0
		AHNS	38.83	0.08	343	8.0	6.0
31395	Pharyngolaryngectomy, with radical neck dissection; with reconstruction	RUC	31.04	0.02	450	15.0	8.0
		AHNS	45.65	0.08	380	10.0	6.0
Family 3-LYMPHADENECTOMY							
38700	Suprahyoid lymphadenectomy	Hvd	8.23	0.02	124	3.0	4.0
		AHNS	13.47	0.07	120	3.0	3.0
38720	Cervical lymphadenectomy (complete)	Hvd	13.59	0.02	177	6.0	4.0

		<i>AHNS</i>	19.91	0.07	150	6.0	4.0
38724	Cervical lymphadenectomy (modified radical neck dissection)	Hvd	14.52	0.04	155	6.0	4.0
		<i>AHNS</i>	22.87	0.08	180	6.0	4.0
Family 4-GLOSSECTOMY							
41120	Glossectomy; less than one-half tongue	Hvd	9.76	0.04	73	5.0	4.0
		<i>AHNS</i>	10.54	0.07	60	3.0	4.0
41130	Glossectomy; hemiglossectomy	Hvd	11.13	0.06	82	4.5	4.0
		<i>AHNS</i>	12.77	0.07	85	4.0	4.0
41135	Glossectomy; partial, with unilateral radical neck dissection	RUC	23.06	0.04	240	10.0	4.0
		<i>AHNS</i>	25.47	0.07	210	6.0	5.0
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	RUC	25.46	0.05	210	10.0	5.0
		<i>AHNS</i>	22.52	0.07	150	8.0	5.0

A	B	C	D	E	F	G	H
CPT	Long Descriptor	Source	RVW	IWPUT	INTRA Min	LOS	OV
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	Hvd	30.01	0.05	283	15.5	6.5
		<i>AHNS</i>	34.93	0.08	285	8.0	6.0
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	RUC	23.01	0.04	210	10.0	5.0
		<i>AHNS</i>	26.81	0.08	190	8.0	5.0
41153	Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection	Hvd	23.73	0.03	238	15.0	5.0
		<i>AHNS</i>	33.68	0.09	270	7.0	5.0
41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	RUC	27.68	0.04	320	11.0	5.0
		<i>AHNS</i>	38.62	0.09	300	9.0	5.0

Family 5-RESECTION OF PALATE

42120	Resection of palate or extensive resection of lesion	Hvd	6.16	0.01	73	3.0	3.0
		<i>AHNS</i>	10.91	0.06	90	2.0	3.0

Family 6-RESECTION OF TONSIL

42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	Hvd	8.75	0.04	91	3.0	3.0
		<i>AHNS</i>	11.90	0.07	90	3.0	3.0
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)	Hvd	14.29	0.03	136	9.5	4.0
		<i>AHNS</i>	15.97	0.07	120	4.0	4.0
42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap	Hvd	24.25	0.04	244	13.0	5.0
		<i>AHNS</i>	29.32	0.08	240	8.0	5.0

Family 7-PHARYNGEAL

42890	Limited pharyngectomy	Hvd	12.92	0.04	122	7.5	4.0
		<i>AHNS</i>	20.23	0.07	150	7.0	5.0
42892	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls	Hvd	15.81	0.03	133	11.5	4.0
		<i>AHNS</i>	23.79	0.07	180	7.0	6.0
42894	Resection of pharyngeal wall requiring closure with myocutaneous flap	Hvd	22.85	0.04	231	13.5	5.0
		<i>AHNS</i>	31.31	0.08	240	9.0	6.0

CMS Draft Comment

CPTDESCRIPTOR2005 RVWGLOB

31225Maxillectomy; without orbital exenteration19.20 090

31230Maxillectomy; with orbital exenteration (en bloc)21.91 090

The American Head and Neck Society (AHNS) believes that the physician work RVUs for 31225 and 31230 are misvalued as discussed below. Our recommended work RVUs are presented in Attachment A.

During the first 5-year-review in 1995, the American Academy of Otolaryngology – Head and Neck Surgery had commented that the proportionality between codes 31225 and 31230 was incorrect. At the time of that comment (1995), the work RVUs for 31225 and 31230 were 15.19 and 21.06 respectively. The Academy comment indicated that although 31225 was a smaller operation than 31230, the intra-operative intensity/complexity was greater to preserve the orbit. The Academy recommendation was to increase 31225 to a value closer to 31230, however, the RUC workgroup instead chose to increase 31225 and decrease 31230, so that these codes were budget neutral. This action was counter to the 5-year-review process, which is to consider codes on their own merit and relative to other similar codes in the MFS, and not simply adjust codes in a budget neutral fashion.

Table 1 below presents the physician time and visit pattern for these maxillectomy procedures and a significant number of RUC-reviewed procedures with similar database time and visit patterns. The table is sorted first by intra-time and then by total time. As seen in the table, the current IWPUT for 31225 (0.036) is still incorrectly less than 31230 (0.040) and the AHNS believes that both are undervalued relative to many other codes in the MFS. An examination of the data also shows how the IWPUT for these two procedures is significantly less than the other procedures presented. Table 2 presents a clinical comparison of work between each of these maxillectomy codes and a RUC-reviewed reference service. Following this table, a typical patient vignette is provided for each code.

Table 1. IWPUT and RUC database information for selected services (misvalued codes are highlighted)

Time

Source	CPT	Long	2005	RVW	IWPUT	TOTAL	TIME	Pre min	Intra min	Imm-SD min	LOS	OV's
RUC	33510	Coronary artery bypass, vein only; single coronary venous graft	28.960	0.0886624515053144								

RUC35876Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft16.970.065395601553052

RUC33533Coronary artery bypass, using arterial graft(s); single arterial graft29.960.135463401556045

RUC32480Removal of lung, other than total pneumonectomy; single lobe (lobectomy)23.710.063552901553073

RUC32440Removal of lung, total pneumonectomy;24.960.065578901604073

RUC44205Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy22.200.089419481653063

RUC23472Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))21.070.079443601653044

RUC43633Gastrectomy, partial, distal; with Roux-en-Y reconstruction23.070.058587751753083

RUC27137Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft21.140.069485751803063

RUC27138Revision of total hip arthroplasty; femoral component only, with or without allograft22.140.074485751803063

RUC35654Bypass graft, with other than vein; axillary-femoral-femoral24.960.089487901803053

RUC35571Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels24.020.083493801803063

RUC50234Nephrectomy with total ureterectomy and bladder cuff; through same incision22.370.072504601804573

RUC35587In-situ vein bypass; popliteal-tibial, peroneal24.710.085506931803063

RUC50240Nephrectomy, partial21.970.055595751806094

RUC31225Maxillectomy; without orbital exenteration19.200.036613901803086

RUC45110Proctectomy; complete, combined abdominoperineal, with colostomy27.960.080624801803094

RUC35103Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)40.440.1176836018060103

RUC33511Coronary artery bypass, vein only; two coronary venous grafts29.960.0796924518053144

RUC35082Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta38.440.0987206018060103

RUC50236Nephrectomy with total ureterectomy and bladder cuff; through separate incision24.820.074561601905084

RUC47780Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract26.460.072606751903083

RUC55873Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)19.440.071395602003013

RUC44202Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis22.010.068489752003053

RUC27487Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component25.230.081513602003064

RUC61510Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma28.410.0836091052004074

RUC35081Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta27.970.07663510820360102

RUC50546Laparoscopy, surgical; nephrectomy, including partial ureterectomy20.450.064460602051843

RUC33534Coronary artery bypass, using arterial graft(s); two coronary arterial grafts32.150.113513402056045

RUC33512Coronary artery bypass, vein only; three coronary venous grafts31.750.0787174520553144

RUC60254Thyroidectomy, total or subtotal for malignancy; with radical neck dissection26.950.091476602103043

RUC33410Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve32.410.080593302105083

RUC35646Bypass graft, with other than vein; aortobifemoral30.950.0926021002103073

RUC44145Colectomy, partial; with coloproctostomy (low pelvic anastomosis)26.380.05869612021045104

RUC33513Coronary artery bypass, vein only; four coronary venous grafts31.950.0777224521053144

RUC33426Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring32.950.102571432206073

RUC33430Replacement, mitral valve, with cardiopulmonary bypass33.450.105571432206073

RUC35631Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal33.950.1016091102253863

RUC47120Hepatectomy, resection of liver; partial lobectomy35.450.079727752253094

RUC33514Coronary artery bypass, vein only; five coronary venous grafts32.700.0757374522553144

Hvd31230Maxillectomy; with orbital exenteration (en bloc)21.910.0406726623735106

RUC50545Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph

nodes, and adrenalectomy)23.960.071484602403042
RUC33535Coronary artery bypass, using arterial graft(s); three coronary arterial grafts34.450.106548402406045
RUC33405Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve34.950.099567402406074
RUC58210Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)28.810.076601752404573
RUC27134Revision of total hip arthroplasty; both components, with or without autograft or allograft28.480.074608902404083
RUC61512Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial35.040.1006261052404073
RUC58952Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)24.970.051660602406093
RUC61518Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull37.260.1046651102404074
RUC35102Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels...30.710.07369110824060112
RUC35566Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels26.880.0546899025840113
RUC33406Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)37.440.101587402606074
RUC33411Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp36.200.096587402606074

Table 2. Work Comparison

HNS

CPTKey

ReferenceComparison of Work

31225

RVW = 19.2023472

RVW = 21.07The pre-operative evaluation of 31225 Maxillectomy without orbital exenteration is similar to 23472 Total shoulder. Both procedures require

- Extensive imaging to determine the extent of the procedure with appropriate informed consent
- Skillful use of powered instrumentation (saws/drills/plating) for adequate resection and reconstruction
- Similar length of surgery

However, the maxillectomy is more intense due to:

- The complexity of the anatomy and the need to preserve the eye
- Decision making for a cancer diagnosis
- More significant total postoperative work to debride the sinus cavity, monitor the patient's airway, nutrition, and prosthetic to achieve voice and swallowing function.
- More complex cosmetic considerations given patients' perception of body image with scars on the face and neck.

31230

RVW = 21.9158952

RVW = 24.97Code 31230 Maxillectomy with orbital exenteration is performed for cancer of the maxillary sinus (complete resection), whereas 58952

Resection of ovarian, tubal or primary peritoneal malignancy is performed for gynecological malignancy as a debulking/incomplete resection procedure. Preoperative work is similar for both types of surgery, although decision making is more complex for cancers of the paranasal sinuses including CT and MRI imaging. The length of surgery in both cases is similar, and the technical demands of both procedures are also similar with major neurovascular structures at risk. Close monitoring may be required after both procedures, however, the maxillectomy procedure will require more significant total postoperative work to monitor the patient's airway, nutrition, and prosthetic to achieve voice and swallowing function. Cancer surveillance is much more extensive, with imaging and debridement of the maxillary cavity performed as necessary. Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck.

31225 Maxillectomy; without orbital exenteration

Typical Patient: A 52-year-old man presents with a history of sinus symptoms with increasing right maxillary pressure and pain, occasional mild epistaxis, and nasal obstruction. Three weeks ago he noted some right cheek swelling and some loosening of two of his right maxillary teeth. He has a mass bulging medially from the lateral nasal wall. There is no proptosis, and extraocular movements are normal. Neck palpation reveals no adenopathy. A CT scan reveals opacification of the right maxillary sinus, with expansion of the sinus medially to partially obstruct the right nasal cavity. There is also erosion of bone in

the sinus floor and lateral wall. The posterior wall appears to be intact, and the floor of the orbit is abutted by the mass, but appears to be intact. A transnasal biopsy of the visible nasal mass shows squamous cell carcinoma. Preoperatively, once a decision to operate has been made, the surgeon reviews pathology and imaging studies with respective pathologists and neuroradiologists, discusses the procedure with the patient, and obtains informed consent. At operation, the maxilla is exposed using a lateral rhinotomy or midface degloving approach. The orbital contents are retracted. Osteotomies are performed. The lesion is removed and margins checked. The cheek and any other raw soft tissue areas are covered with split thickness skin grafts from the anterior thigh (Note: Harvesting of graft(s) is/are reported separately). The nasolacrimal duct is stented. The previously fashioned obturator is secured to the remaining teeth with wire clasps, and is rigidly fixed or suspended to adjacent remaining bone with wires or screws. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred, that the patient is able to maintain his nutrition, and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

31230 Maxillectomy; with orbital exenteration (en bloc)

Typical Patient: A 59-year-old man presents with a one year history of sinus symptoms. Recently, he has noted increasing pain and swelling in the left cheek, and the onset of diplopia and visual blurring in his left eye. There is marked proptosis and pupillary response is sluggish in his left eye. Extraocular movements are restricted in all directions of gaze and neck palpation reveals no adenopathy. A CT scan shows opacification of the left maxillary sinus, with erosion of the roof of the sinus, with what appears to be a soft tissue mass invading the orbit. These findings are confirmed on MRI, which shows apparent clear-cut invasion of the orbital muscle cone by tumor. A transnasal biopsy of the visible nasal mass shows squamous cell carcinoma. Preoperatively, once a decision to operate has been made, the surgeon reviews pathology and imaging studies and discusses the procedure with the patient and obtains informed consent. At operation, the maxilla is exposed using a lateral rhinotomy approach. The orbital periosteum is elevated, and the orbital contents are left attached to the orbital floor. Osteotomies are performed. The optic nerve is transected as close to the orbital apex as possible. The lesion is removed and margins checked. The cheek and any other raw soft tissue areas are covered

with split thickness skin grafts from the anterior thigh (Note: Harvesting of graft(s) is/are reported separately). The previously fashioned obturator is secured to the remaining teeth with wire clasps, and is rigidly fixed to adjacent remaining bone with wires or screws. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred, that the patient is able to maintain his nutrition, and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

CPT	DESCRIPTOR	2005 RVW	GLOB
31360	Laryngectomy; total, without radical neck dissection	17.05	090
31365	Laryngectomy; total, with radical neck dissection	24.12	090
31367	Laryngectomy; subtotal supraglottic, without radical neck dissection	21.83	090
31368	Laryngectomy; subtotal supraglottic, with radical neck dissection	27.05	090
31370	Partial laryngectomy (hemilaryngectomy); horizontal	21.35	090
31375	Partial laryngectomy (hemilaryngectomy); lateroververtical	20.18	090
31380	Partial laryngectomy (hemilaryngectomy); anterovertical	20.18	090
31382	Partial laryngectomy (hemilaryngectomy); antero-latero-vertical	20.49	090
31390	Pharyngolaryngectomy, with radical neck dissection; without reconstruction	27.49	090
31395	Pharyngolaryngectomy, with radical neck dissection; with reconstruction	31.04	090

The American Head and Neck Society (AHNS) believes that the physician work RVUs for the laryngectomy CPT codes shown above are misvalued as discussed below. Our recommended work RVUs are presented in Attachment A.

During the first 5-year-review in 1995, the American Academy of Otolaryngology – Head and Neck Surgery had commented that the work RVUs for four of these codes were undervalued. The RUC disagreed with the Academy’s rationales for 31360 and 31365. The RUC recommended increases for 31390 and 31395. In reviewing this entire family of codes, the AHNS believes that there is both a rank order anomaly within this family and a relative anomaly with other codes in the MFS. A review of the entire family is necessary to place the codes in correct order relative to each other and relative to other similar procedures.

Table 1 below presents the physician time and visit pattern for these laryngectomy procedures and a significant number of RUC-reviewed procedures with similar time and visit patterns. The table is sorted first by intra-time and then by total time. As seen in this table, most codes have significantly higher work RVUs (RVWs), than the laryngectomy codes, even though the time and visit pattern may be similar or greater. Another measure often used for comparison of physician work is the intra-work per unit time (IWPUT), which is shown for all codes in the table. An examination of these data show how the IWPUT values for the laryngectomy procedures are not only significantly less than the other procedures presented, but for almost all of these major operations, which take three to eight hours, the IWPUT is less than the intensity for E/M services. Table 2 presents a clinical comparison of work between each of the laryngectomy codes and a RUC-reviewed reference service. Following this table, a typical patient vignette is provided for each laryngectomy procedure.

Table 1. IWPUT and RUC database information for selected services (misvalued codes are highlighted)

Time Source	CPT	Long	2005 RVW	IWPUT	TOTAL TIME	Pre min	Intra min	Imm-SD min	LOS	OV's
RUC	15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)	17.81	0.055	474	60	150	30	6	4
RUC	35131	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common,	24.96	0.099	501	105	150	40	6	3

		hypogastric, external)								
RUC	44140	Colectomy, partial; with anastomosis	20.97	0.072	502	90	150	40	7	3
RUC	43631	Gastrectomy, partial, distal; with gastroduodenostomy	22.56	0.079	507	75	150	30	8	3
RUC	44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	25.32	0.090	524	60	150	30	8	2
RUC	44640	Closure of intestinal cutaneous fistula	21.62	0.065	524	60	150	30	8	2
RUC	43632	Gastrectomy, partial, distal; with gastrojejunostomy	22.56	0.065	562	75	150	30	8	3
RUC	32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple	21.97	0.061	577	90	150	45	7	3
RUC	61313	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral	24.89	0.068	632	100	150	40	10	3
RUC	33510	Coronary artery bypass, vein only; single coronary venous graft	28.96	0.088	662	45	150	53	14	4
RUC	35876	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft	16.97	0.065	395	60	155	30	5	2
RUC	33533	Coronary artery bypass, using arterial graft(s); single arterial graft	29.96	0.135	463	40	155	60	4	5
RUC	32480	Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	23.71	0.063	552	90	155	30	7	3
Hvd	31375	Partial laryngectomy (hemilaryngectomy); laterovertical	20.18	0.057	537	59	160	30	11	4
RUC	32440	Removal of lung, total pneumonectomy;	24.96	0.065	578	90	160	40	7	3
Hvd	31380	Partial laryngectomy (hemilaryngectomy); anterovertical	20.18	0.055	540	59	163	30	11	4
RUC	44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy	22.20	0.089	419	48	165	30	6	3
RUC	23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	21.07	0.079	443	60	165	30	4	4
RUC	43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	23.07	0.058	587	75	175	30	8	3
Hvd	31370	Partial laryngectomy (hemilaryngectomy); horizontal	21.35	0.023	741	60	177	33	17	5
Hvd	31367	Laryngectomy; subtotal supraglottic, without radical neck dissection	21.83	0.026	743	60	179	33	17	5
RUC	44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	25.04	0.097	439	45	180	30	5	3
RUC	27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation	17.89	0.052	474	60	180	30	5	4
RUC	27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	21.14	0.069	485	75	180	30	6	3
RUC	27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	22.14	0.074	485	75	180	30	6	3
RUC	35654	Bypass graft, with other than vein; axillary-femoral-femoral	24.96	0.089	487	90	180	30	5	3
RUC	35571	Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels	24.02	0.083	493	80	180	30	6	3
RUC	50234	Nephrectomy with total ureterectomy and bladder cuff; through same								

		incision	22.37	0.072	504	60	180	45	7	3
RUC	35587	In-situ vein bypass; popliteal-tibial, peroneal	24.71	0.085	506	93	180	30	6	3
RUC	50240	Nephrectomy, partial	21.97	0.055	595	75	180	60	9	4
RUC	45110	Proctectomy; complete, combined abdominoperineal, with colostomy	27.96	0.080	624	80	180	30	9	4
Hvd	31360	Laryngectomy; total, without radical neck dissection	17.05	0.035	625	62	139	27	10	4
RUC	35103	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)	40.44	0.117	683	60	180	60	10	3
RUC	33511	Coronary artery bypass, vein only; two coronary venous grafts	29.96	0.079	692	45	180	53	14	4
RUC	35082	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	38.44	0.098	720	60	180	60	10	3
RUC	50236	Nephrectomy with total ureterectomy and bladder cuff; through separate incision	24.82	0.074	561	60	190	50	8	4
RUC	47780	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract	26.46	0.072	606	75	190	30	8	3
RUC	55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)	19.44	0.071	395	60	200	30	1	3
RUC	44202	Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis	22.01	0.068	489	75	200	30	5	3
RUC	27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	25.23	0.081	513	60	200	30	6	4
RUC	58951	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	22.35	0.061	536	75	200	33	6	2
RUC	61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	28.41	0.083	609	105	200	40	7	4
Hvd	31382	Partial laryngectomy (hemilaryngectomy); antero-latero-vertical	20.49	0.039	633	61	200	31	11	5
RUC	35081	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta	27.97	0.076	635	108	203	60	10	2
RUC	50546	Laparoscopy, surgical; nephrectomy, including partial ureterectomy	20.45	0.064	460	60	205	18	4	3
RUC	33534	Coronary artery bypass, using arterial graft(s); two coronary arterial grafts	32.15	0.113	513	40	205	60	4	5
RUC	33512	Coronary artery bypass, vein only; three coronary venous grafts	31.75	0.078	717	45	205	53	14	4
RUC	60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	26.95	0.091	476	60	210	30	4	3
RUC	33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	32.41	0.080	593	30	210	50	8	3
RUC	35646	Bypass graft, with other than vein; aortobifemoral	30.95	0.092	602	100	210	30	7	3
RUC	44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	26.38	0.058	696	120	210	45	10	4

RUC	33513	Coronary artery bypass, vein only; four coronary venous grafts	31.95	0.077	722	45	210	53	14	4
RUC	33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	32.95	0.102	571	43	220	60	7	3
RUC	33430	Replacement, mitral valve, with cardiopulmonary bypass	33.45	0.105	571	43	220	60	7	3
RUC	35631	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal	33.95	0.101	609	110	225	38	6	3
RUC	47120	Hepatectomy, resection of liver; partial lobectomy	35.45	0.079	727	75	225	30	9	4
RUC	33514	Coronary artery bypass, vein only; five coronary venous grafts	32.70	0.075	737	45	225	53	14	4
RUC	50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	23.96	0.071	484	60	240	30	4	2
RUC	33535	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts	34.45	0.106	548	40	240	60	4	5
RUC	33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	34.95	0.099	567	40	240	60	7	4
RUC	58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	28.81	0.076	601	75	240	45	7	3
RUC	27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	28.48	0.074	608	90	240	40	8	3
RUC	61512	Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	35.04	0.100	626	105	240	40	7	3
RUC	58952	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)	24.97	0.051	660	60	240	60	9	3
RUC	61518	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull	37.26	0.104	665	110	240	40	7	4
RUC	35102	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)	30.71	0.073	691	108	240	60	11	2
RUC	35566	Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels	26.88	0.054	689	90	258	40	11	3
RUC	33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)	37.44	0.101	587	40	260	60	7	4
RUC	33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp	36.20	0.096	587	40	260	60	7	4
RUC	33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	39.94	0.109	621	43	270	60	7	3
		In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal								

RUC	35585	artery	28.35	0.057	701	90	270	40	11	3
RUC	61700	Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation	50.44	0.116	838	120	270	45	11	4
RUC	33536	Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts	37.44	0.103	583	40	275	60	4	5
RUC	58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	31.95	0.072	671	90	285	45	6	3
RUC	33253	Operative incisions and reconstruction of atria for treatment of atrial fibrillation or atrial flutter (eg, maze procedure)	31.01	0.080	593	90	300	150	0	2
RUC	33860	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension;	37.94	0.079	712	60	300	70	8	3
RUC	33875	Descending thoracic aorta graft, with or without bypass	33.01	0.066	728	60	300	60	10	2
RUC	31365	Laryngectomy; total, with radical neck dissection	24.12	0.028	819	90	300	40	13	4
RUC	43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagostomy, with or without pyloroplasty (transhiatal)	39.94	0.057	861	90	300	45	10	4
RUC	31390	Pharyngolaryngectomy, with radical neck dissection; without reconstruction	27.49	0.034	870	90	300	45	13	6
Hvd	31368	Laryngectomy; subtotal supraglottic, with radical neck dissection	27.05	0.023	961	67	307	36	20	6
RUC	48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreateojejunostomy	47.82	0.073	979	90	315	45	13	4
RUC	33870	Transverse arch graft, with cardiopulmonary bypass	43.93	0.090	742	60	330	70	8	3
RUC	48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreateojejunostomy	47.93	0.067	1013	90	345	45	13	4
RUC	33863	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction	44.93	0.085	772	60	360	70	8	3
RUC	31395	Pharyngolaryngectomy, with radical neck dissection; with reconstruction	31.04	0.022	1151	100	450	60	15	8
RUC	21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	46.37	0.078	846	120	480	n/a	7	6
RUC	20955	Bone graft with microvascular anastomosis; fibula	39.15	0.062	864	100	480	n/a	9	6
RUC	20973	Free osteocutaneous flap with microvascular anastomosis; great toe with web space	45.69	0.063	1012	120	540	n/a	7	6
RUC	26554	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double	54.87	0.066	1137	120	595	60	11	8

Table 2. Work Comparison

HNS CPT	Key Reference	Comparison of Work
31360 RVW = 17.05	32440 RVW = 24.96	<ul style="list-style-type: none"> • The work associated with 31360 <i>Laryngectomy; total, without radical neck dissection</i> is of similar complexity to the reference 32440 <i>Total pneumonectomy</i> in the following ways: <ul style="list-style-type: none"> • A portion of the respiratory tract is resected and closed • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved, if not involved with tumor. <p>Additional complexity exists in the following ways:</p> <ul style="list-style-type: none"> • Intraoperatively, a partial thyroidectomy is usually performed and attention must be paid to preservation of thyroid and parathyroid function. • The alimentary tract must be closed following removal of the larynx and this area is at risk for salivary fistula and wound healing complications. Pharyngeal closure is done in a contaminated field necessitating meticulous, water-tight suturing techniques. Patients are provided nutrition via tube feedings to allow an appropriate amount of time for wound healing. • Monitoring for wound complications in an irradiated field. • Cosmetic considerations are complex given patients' perception of body image with scars on the face and neck. • Code 31360 includes extensive voice and swallowing rehabilitation, care of the stoma, and counseling for psychosocial adjustment.
31365 RVW = 24.12	43107 RVW = 39.94	<p>The work associated with 31365 <i>Laryngectomy; total, with radical neck dissection</i> is of similar complexity to the reference CPT 43107 <i>Total or near total esophagectomy, without thoracotomy with pharyngogastrostomy or cervical esophagogastrostomy</i> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the alimentary tract is resected and reanastomosed or closed. • Work is done in a contaminated field which necessitates meticulous, water-tight closure. There is risk for postoperative wound healing complications including salivary fistula. Wound healing complications can prolong and intensify the postoperative management and put the patients at risk for great vessel (carotid artery) erosion. Patients are provided nutrition via alternative means, typically alimentary feedings. • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech, swallowing, and

		<p>shoulder function and perfusion of the neck, head, and brain must be dissected and preserved if not directly involved with tumor.</p> <ul style="list-style-type: none"> • Cosmetic considerations are complex given patients' perception of body image with scars on the face and neck. • Code 31365 includes extensive voice and swallowing rehabilitation, care of the stoma, and counseling for psychosocial adjustment, as well as shoulder and neck rehabilitation to preserve mobility.
<p>31367 RVW = 21.83</p>	<p>32480 RVW = 23.71</p>	<p>The work associated with 31367 <u>laryngectomy, subtotal supraglottic, without radical neck dissection</u> is of similar complexity to the reference 32480 <u>removal of lung, other than total pneumonectomy; single lobe</u> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the respiratory tract is resected and closed • Repair involving fine suturing of mucosal edges and positioning of cartilage remnants is critical to optimal functional outcome • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. <p>Additional complexity exists in the following ways:</p> <ul style="list-style-type: none"> • The intraoperative judgment surrounding extent of dissection imposes an additional complexity 31367 compared with 32480. • Margin assessment is extensive. There are multiple surfaces that must be checked with frozen section specimens. • Unlike pneumonectomy, the alimentary tract is entered and must be closed for laryngectomy, subtotal supraglottic. Work is done in a contaminated field which necessitates meticulous, water-tight closure. There is a risk for postoperative wound healing complications including salivary and tracheocutaneous fistula. Patients are provided nutrition via alternative means, typically alimentary feedings. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck. . • Rehabilitation for the patient in the postoperative period involves discussion of swallowing rehabilitation, care of the tracheostomy and decannulation.

<p>31368 RVW = 27.05</p>	<p>43107 RVW = 39.94</p>	<p>The work associated with 31368 <u><i>laryngectomy; subtotal supraglottic, with radical neck dissection</i></u> is of similar complexity to the reference 43107 <u><i>total or near total esophagectomy, without thoracotomy with pharyngogastrostomy or cervical esophagogastronomy</i></u> in the following ways::</p> <ul style="list-style-type: none"> • A portion of the alimentary tract is resected and reanastomosed or closed. • Repair involving fine suturing of mucosal edges and positioning of cartilage remnants is critical to optimal functional outcome • Work is done in a contaminated field which necessitates meticulous, water-tight closure. There is risk for postoperative wound healing complications including salivary and laryngocutaneous fistula. Wound healing complications can prolong and intensify the postoperative management and put the patients at risk for great vessel (carotid artery) erosion. Patients are provided nutrition via alternative means, typically alimentary feedings. • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech, swallowing, and shoulder function and perfusion of the neck, head, and brain must be dissected and preserved if not directly involved with tumor. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck.. • Rehabilitation for the patient in the postoperative period involves discussion of swallowing rehabilitation, care of the tracheostomy and decannulation, as well as shoulder and neck exercises to preserve mobility.
<p>31370 RVW = 21.35</p>	<p>32480 RVW = 23.71</p>	<p>The work associated with 31370 <u><i>Partial laryngectomy (hemilaryngectomy); horizontal</i></u> is of similar complexity to the reference CPT 32480 <u><i>Removal of lung, other than total pneumonectomy; single lobe</i></u> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the respiratory tract is resected and closed • Repair involving fine suturing of mucosal edges and positioning of cartilage remnants is critical to optimal functional outcome • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. • The margin assessment (intraop) is more complex in partial laryngectomy than lobectomy. There are multiple surfaces that must be checked with frozen section specimens. • There is a risk for postoperative wound healing complications

		<p>including salivary and tracheocutaneous fistula. Patients are provided nutrition via alternative means, typically alimentary feedings.</p> <ul style="list-style-type: none"> • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck.. • Rehabilitation for the patient in the postoperative period involves discussion of swallowing rehabilitation, care of the tracheostomy and decannulation.
<p>31375 RVW = 20.18</p>	<p>32480 RVW = 23.71</p>	<p>The work associated with 31375 <u>Partial laryngectomy (hemilaryngectomy); laterovertical</u> is of similar complexity to the reference CPT 32480 <u>Removal of lung, other than total pneumonectomy; single lobe</u> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the respiratory tract is resected and closed • Repair involving fine suturing of mucosal edges and positioning of cartilage remnants is critical to optimal functional outcome • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. • The margin assessment (intraop) is more complex in partial laryngectomy than lobectomy. There are multiple surfaces that must be checked with frozen section specimens. • There is a risk for postoperative wound healing complications including salivary and tracheocutaneous fistula. Patients are provided nutrition via alternative means, typically alimentary feedings. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck.. • Rehabilitation for the patient in the postoperative period involves discussion of swallowing rehabilitation, care of the tracheostomy and decannulation.
<p>31380 RVW = 20.18</p>	<p>32480 RVW = 23.71</p>	<p>The work associated with 31380 <u>Partial laryngectomy (hemilaryngectomy); anterovertical</u> is of similar complexity to the reference CPT 32480 <u>Removal of lung, other than total pneumonectomy; single lobe</u> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the respiratory tract is resected and closed • Repair involving fine suturing of mucosal edges and positioning of cartilage remnants is critical to optimal functional outcome • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. • The margin assessment (intraop) is more complex in partial

		<p>laryngectomy than lobectomy. There are multiple surfaces that must be checked with frozen section specimens.</p> <ul style="list-style-type: none"> • There is a risk for postoperative wound healing complications including salivary and tracheocutaneous fistula. Patients are provided nutrition via alternative means, typically alimentary feedings. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck. . • Rehabilitation for the patient in the postoperative period involves discussion of swallowing rehabilitation, care of the tracheostomy and decannulation.
<p>31382 RVW = 20.49</p>	<p>32480 RVW = 23.71</p>	<p>The work associated with 31382 <u>Partial laryngectomy (hemilaryngectomy); antero-latero-vertical</u> is of similar complexity to the reference CPT 32480 <u>Removal of lung, other than total pneumonectomy; single lobe</u> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the respiratory tract is resected and closed • Repair involving fine suturing of mucosal edges and positioning of cartilage remnants is critical to optimal functional outcome • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. • The margin assessment (intraop) is more complex in partial laryngectomy than lobectomy. There are multiple surfaces that must be checked with frozen section specimens. • There is a risk for postoperative wound healing complications including salivary and tracheocutaneous fistula. Patients are provided nutrition via alternative means, typically alimentary feedings. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck. • Rehabilitation for the patient in the postoperative period involves discussion of swallowing rehabilitation, care of the tracheostomy and decannulation.

<p>31390 RVW = 27.49</p>	<p>43107 RVW = 39.94</p>	<p>The work associated with 31390 <u>Pharyngolaryngectomy; total, with radical neck dissection; without reconstruction</u> is of similar complexity to the reference CPT 43107 <u>Total or near total esophagectomy, without thoracotomy with pharyngogastrostomy or cervical esophagogastronomy</u> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the alimentary tract is resected and reanastomosed or closed. • Work is done in a contaminated field which necessitates meticulous, water-tight closure. There is risk for postoperative wound healing complications including salivary fistula. Wound healing complications can prolong and intensify the postoperative management and put the patients at risk for great vessel (carotid artery) erosion. Patients are provided nutrition via alternative means, typically alimentary feedings. • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Neurovascular structures critical for speech, swallowing, and shoulder function and perfusion of the neck, head, and brain must be dissected and preserved if not directly involved with tumor. Intraoperatively, a partial thyroidectomy is usually performed and attention must be paid to preservation of thyroid and parathyroid function. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck. • Rehabilitation for the patient in the postoperative period involves discussion of voice rehabilitation, care of the stoma, and precautions related to the stoma as well as shoulder and neck exercises to preserve mobility.
<p>31395 RVW = 31.04</p>	<p>43107 RVW = 39.94</p>	<p>The work associated with 31395 <u>Pharyngolaryngectomy; total, with radical neck dissection; with reconstruction</u> is of similar complexity to the reference CPT 43107 <u>Total or near total esophagectomy, without thoracotomy with pharyngogastrostomy or cervical esophagogastronomy</u> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the alimentary tract is resected. • Work is done in a contaminated field which necessitates meticulous, water-tight closure. There is risk for postoperative wound healing complications including salivary fistula. Wound healing complications can prolong and intensify the postoperative management and put the patients at risk for great vessel (carotid artery) erosion. Patients are provided nutrition via alternative means, typically alimentary feedings. • Insetting of the reconstructive flap requires meticulous fashioning and suturing to minimize the risk of wound healing complications. • Airway management is critical as patients' airways are often affected

		<p>by both tumors and surgical procedures in this region.</p> <ul style="list-style-type: none"> • Neurovascular structures critical for speech, swallowing, and shoulder function and perfusion of the neck, head, and brain must be dissected and preserved if not directly involved with tumor. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck. Furthermore, depression and altered body image are common amongst laryngectomees. • Rehabilitation for the patient in the postoperative period involves discussion of voice rehabilitation, care of the stoma, and precautions related to the stoma as well as shoulder and neck exercises to preserve mobility.
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31360 Laryngectomy; total, without radical neck dissection

Typical Patient: A 65-year-old man, with a history of heavy tobacco use and alcohol consumption, presents with recurrent cancer involving the arytenoids, true vocal fold, and infraglottic larynx, previously treated with full course chemoradiotherapy. CT scan, PET scan, and laryngoscopy with biopsy confirm recurrence limited to the larynx. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, the larynx is exposed via an apron incision and subsequently resected with primary pharyngeal mucosal closure, and a matured laryngostome is created. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed.

31365 Laryngectomy; total, with radical neck dissection

Typical Patient: A 65-year-old man, with a history of heavy tobacco use and alcohol consumption, presents with recurrent cancer involving the arytenoids, true vocal fold, and infraglottic larynx, previously treated with full course chemoradiotherapy. CT scan, PET scan, and laryngoscopy with biopsy confirm recurrence in the larynx and a 3.5 cm lymph node in the ipsilateral neck. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, an apron incision is fashioned and a radical neck dissection is performed with sacrifice of the sternocleidomastoid muscle, internal jugular vein, cranial nerve XI, and the lymph nodes in Levels I-V. Next, a total laryngectomy is performed with primary pharyngeal mucosal closure and a matured tracheostome is created. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to ensure that adequate healing has occurred, to monitor shoulder rehabilitation, and to ensure that the patient is able to maintain his nutrition and that no airway problem has developed.

31367 Laryngectomy; subtotal supraglottic, without radical neck dissection

Typical Patient: A 56-year-old man with a history of tobacco and alcohol consumption presents with cancer limited to the supraglottic portion of the larynx. Pulmonary function studies indicate adequate pulmonary reserve. The tumor is small and judged to have a low risk for regional metastasis. PET scan and/or CT scan are negative for nodal disease. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a tracheotomy is performed, followed by an incision over the thyroid cartilage. The larynx is exposed and the portion of the larynx above the true vocal cords is resected. The laryngeal remnant is suspended and

reapproximated to the tongue base. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no aspiration or other airway problem has developed.

31368 Laryngectomy, subtotal supraglottic, with radical neck dissection

Typical Patient: A 56-year-old man with a history of tobacco and alcohol consumption presents with cancer limited to the supraglottic portion of the larynx and a 6 cm mass in the neck. Pulmonary function studies indicate adequate pulmonary reserve. Distant metastatic workup is negative. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, an apron incision is fashioned and a radical neck dissection is performed with sacrifice of the sternocleidomastoid muscle, internal jugular vein, cranial nerve XI, and the lymph nodes in Levels I-V. The larynx is exposed and the portion of the larynx above the true vocal cords is resected. The laryngeal remnant is suspended and reapproximated to the tongue base. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to ensure that adequate healing has occurred, to monitor shoulder rehabilitation, and to ensure that the patient is able to maintain his nutrition and that no airway problem has developed.

31370 Partial laryngectomy (hemilaryngectomy); horizontal

Typical Patient: A 59-year-old man, with a history of tobacco use and alcohol consumption, presents with cancer limited to one aryepiglottic fold and epiglottis. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a tracheotomy is performed, followed by a horizontal cervical skin incision in a skin crease. The strap muscles are split in the midline and the thyroid cartilage exposed. The perichondrium of the thyroid cartilage is incised and elevated, and a horizontal incision made below the level of the tumor. The airway is entered through an infrahyoid pharyngotomy exposing the tumor and the affected portion of the supraglottic larynx is resected. The laryngeal remnant is suspended and reapproximated to the tongue base. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed.

31375 Partial laryngectomy (hemilaryngectomy); laterovertical

Typical Patient: A 62-year-old man with a history of tobacco and alcohol use, presents with recurrent T1aN0M0 squamous cell carcinoma of the right true vocal cord previously treated with radiation. Pulmonary function studies demonstrate adequate pulmonary reserve. Distant metastatic work up is negative. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a tracheotomy is performed. A separate horizontal incision is created in the neck and the larynx is exposed by reflecting the strap muscles laterally. Thyrotomy is performed and the tumor is resected, including the false and true vocal cord. Reconstruction of the defect is completed using local tissue. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed.

31380 Partial laryngectomy (hemilaryngectomy); anterovertical

Typical Patient: A 62-year-old man with a history of tobacco and alcohol use, presents with recurrent T1bN0M0 squamous cell carcinoma of the anterior commissure previously treated with radiation. Pulmonary function studies demonstrate adequate pulmonary reserve. Distant metastatic work up is negative. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a tracheotomy is performed. A separate horizontal incision is created in the neck and the larynx is exposed by reflecting the strap muscles laterally. Thyrotomy is performed and the tumor is resected, including anterior portion of both the false and true vocal cords with the anterior commissure. Reconstruction of the defect is completed using a keel. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed.

31382 Partial laryngectomy (hemilaryngectomy); antero-latero-vertical

Typical Patient: A 62-year-old man with a history of tobacco and alcohol use, presents with recurrent T1bN0M0 squamous cell carcinoma of the right true vocal cord with extension across the anterior commissure, previously treated with radiation. Pulmonary function studies demonstrate adequate pulmonary reserve. Distant metastatic work up is negative. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a tracheotomy is performed. A separate horizontal incision is created in the neck and the larynx is exposed by reflecting the strap muscles laterally. Thyrotomy is performed and the tumor is resected, including the false and true vocal cord with anterior commissure and a portion of the contralateral vocal cord. Reconstruction of the defect is completed using local tissue and a keel. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed.

31390 Pharyngolaryngectomy, with radical neck dissection; without reconstruction

Typical Patient: A 60-year old man who is a heavy smoker presents with weight loss, hoarseness, and coughing. He has a paralyzed vocal cord and a tumor involving the medial wall of the piriform sinus and destruction of the thyroid cartilage. There is also a 7.0 cm ipsilateral metastatic lymph node. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, an apron incision is fashioned and a radical neck dissection is performed with sacrifice of the sternocleidomastoid muscle, internal jugular vein, cranial nerve XI, and the lymph nodes in Levels I-V. A wide-field pharyngolaryngectomy and primary mucosal closure without flap is performed. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to ensure that adequate healing has occurred, to monitor shoulder rehabilitation, and to ensure that the patient is able to maintain his nutrition and that no airway problem has developed.

31395 Pharyngolaryngectomy, with radical neck dissection; with reconstruction

Typical Patient: A 60-year old man who is a heavy smoker presents with weight loss, hoarseness, and coughing. He has a paralyzed vocal cord and a tumor involving the medial and lateral wall of the piriform sinus and destruction of the thyroid cartilage. There is also a 7.0 cm ipsilateral metastatic lymph node.

Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. Reconstructive options are reviewed with a reconstructive surgeon. At operation, an apron incision is fashioned and a radical neck dissection is performed with sacrifice of the sternocleidomastoid muscle, internal jugular vein, cranial nerve XI, and the lymph nodes in Levels I-V. A wide-field pharyngolaryngectomy is performed. The reconstructive surgeon harvests and rotates a flap (separately billed) and the flap is inset. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to ensure that adequate healing has occurred, to monitor shoulder rehabilitation, and to ensure that the patient is able to maintain his nutrition and that no airway problem has developed.

CMS Draft Comment

CPTDESCRIPTOR2005 RVWIWPUTGLOB

38700Suprahyoid lymphadenectomy8.23 0.020 090

38720Cervical lymphadenectomy (complete)13.59 0.027090

38724Cervical lymphadenectomy (modified radical neck dissection)14.52
0.028 090

The American Head and Neck Society (AHNS) believes that the physician work RVUs for the lymphadenectomy CPT codes shown above are misvalued as discussed below. Our recommended work RVUs are presented in Attachment A.

During the first 5-year-review in 1995, the American Academy of Otolaryngology – Head and Neck Surgery had commented that the work RVUs for 38720 and 38724 were undervalued. The RUC disagreed with the Academy’s recommendations for both of these codes. AHNS believes that all three of these codes are undervalued relative to axillary lymphadenectomy codes 38740 and 38745, which have less intra-operative time and less total work, but have higher work-RVUs (10.01 and 13.08 respectively).

Table 1 below presents the physician time and visit pattern for these lymphadenectomy procedures and a significant number of RUC-reviewed procedures with similar time and visit patterns. The table is sorted first by intra-time and then by total time. As seen in this table, most codes have significantly higher work RVUs (RVWs), than the lymphadenectomy codes, even though the time and visit pattern may be similar or greater. Another measure often used for comparison of physician work is the intra-work per unit time (IWPUT) value, which is shown for all codes in the table. An examination of these data show how the IWPUT for the lymphadenectomy procedures is significantly less than the other procedures presented. Table 2 presents a clinical comparison of work between each of the lymphadenectomy codes and a RUC-reviewed reference service. Following this table, a typical patient vignette and detailed service description is provided for each lymphadenectomy procedure.

Table 1. IWPUT and RUC database information for selected services
(misvalued codes are highlighted)

Time

Source	CPT	Long	2005 RVW	IWPUT	TOTAL TIME	Pre min	Intra min	Imm-SD	min	LOS	OV's
RUC	38740	Axillary lymphadenectomy; superficial	10.01	0.094	229	60	60	30	13		
RUC	44950	Appendectomy;	9.99	0.078	247	50	60	25	32		

RUC38745Axillary lymphadenectomy; complete13.08 0.094 26758902513

RUC36830Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)11.98 0.081 215551202501

RUC36833Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)11.93 0.079 225451204501

RUC33249Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator14.21 0.091 24960120003

RUC36819Arteriovenous anastomosis, open; by upper arm basilic vein transposition13.98 0.084 253251201522

RUC61793Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions17.21 0.103 305851201812

RUC35256Repair blood vessel with vein graft; lower extremity18.33 0.100 341601203042

RUC35372Thromboendarterectomy, with or without patch graft; deep (profunda) femoral17.97 0.099 342801203032

RUC49566Repair recurrent incisional or ventral hernia; incarcerated or strangulated14.38 0.063 348451203042

RUC35011Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision17.97 0.097 352901203032

RUC58740Lysis of adhesions (salpingolysis, ovariolysis)13.98 0.060 359681203332

RUC23420Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)13.28 0.054 365451203025

Hvd38700Suprahyoid lymphadenectomy8.23 0.021 334541242234

RUC35221Repair blood vessel, direct; intra-abdominal24.35 0.087 496531254572

RUC47760Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract25.81 0.097 557751304583

RUC50715Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis18.87 0.076 434601354563

RUC35301Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision18.67 0.077 416901444042

RUC54410Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session15.48 0.065 364501453023

RUC19318Reduction mammoplasty15.60 0.071 336601503014

RUC60271Thyroidectomy, including substernal thyroid; cervical approach16.80 0.071 363601503032

RUC43280Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)17.22 0.070 4001001503032

RUC35141Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial19.97 0.084 412901503042

RUC63017Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar15.92 0.055 424901503033

RUC34804Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis22.97 0.103 4281201503532

RUC24363Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)18.46 0.071 429601503035

RUC58200Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)21.56 0.088 435601504552

RUC35656Bypass graft, with other than vein; femoral-popliteal19.50 0.075 439901503062

RUC34802Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)22.97 0.100 4481351504032

RUC15738Muscle, myocutaneous, or fasciocutaneous flap; lower extremity17.89 0.060 450601503074

RUC63015Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical19.32 0.073 451901503843

RUC35151Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery22.61 0.093 4561001503053

RUC27486Revision of total knee arthroplasty, with or without allograft; one component19.24 0.068 463601503064

RUC35351Thromboendarterectomy, with or without patch graft; iliac22.97 0.091 464901503052

RUC35665Bypass graft, with other than vein; iliofemoral20.97 0.080 4641001503053

RUC35666Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery22.16 0.086 473901503063

RUC38720Cervical lymphadenectomy (complete)13.59 0.027 474601503064

RUC15732Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)17.81

0.055 474601503064

RUC35131 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external) 24.96 0.099 5011051504063

RUC44140 Colectomy, partial; with anastomosis 20.97 0.072 502901504073

RUC43631 Gastrectomy, partial, distal; with gastroduodenostomy 22.56 0.079 507751503083

RUC44626 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure) 25.32 0.090 524601503082

RUC44640 Closure of intestinal cutaneous fistula 21.62 0.065 524601503082

RUC43632 Gastrectomy, partial, distal; with gastrojejunostomy 22.56 0.065 562751503083

RUC32500 Removal of lung, other than total pneumonectomy; wedge resection, single or multiple 21.97 0.061 577901504573

RUC61313 Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral 24.89 0.068 63210015040103

RUC33510 Coronary artery bypass, vein only; single coronary venous graft 28.96 0.088 6624515053144

RUC35876 Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft 16.97 0.065 395601553052

RUC33533 Coronary artery bypass, using arterial graft(s); single arterial graft 29.96 0.135 463401556045

RUC32480 Removal of lung, other than total pneumonectomy; single lobe (lobectomy) 23.71 0.063 552901553073

RUC32440 Removal of lung, total pneumonectomy; 24.96 0.065 578901604073

RUC44205 Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy 22.20 0.089 419481653063

RUC23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) 21.07 0.079 443601653044

RUC43633 Gastrectomy, partial, distal; with Roux-en-Y reconstruction 23.07 0.058 587751753083

RUC44204 Laparoscopy, surgical; colectomy, partial, with anastomosis 25.04 0.097 439451803053

RUC27513 Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation 17.89 0.052 474601803054

RUC27137 Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft 21.14 0.069 485751803063

RUC27138 Revision of total hip arthroplasty; femoral component only, with or without allograft 22.14 0.074 485751803063

RUC35654Bypass graft, with other than vein; axillary-femoral-femoral24.96
0.089 487901803053

RUC35571Bypass graft, with vein; popliteal-tibial, -peroneal artery or
other distal vessels24.02 0.083 493801803063

RUC38724Cervical lymphadenectomy (modified radical neck dissection)14.52
0.028 504601803064

RUC50234Nephrectomy with total ureterectomy and bladder cuff; through same
incision22.37 0.072 504601804573

RUC35587In-situ vein bypass; popliteal-tibial, peroneal24.71 0.085
506931803063

RUC50240Nephrectomy, partial21.97 0.055 595751806094

RUC45110Proctectomy; complete, combined abdominoperineal, with
colostomy27.96 0.080 624801803094

RUC35103Direct repair of aneurysm, pseudoaneurysm, or excision (partial or
total) and graft insertion, with or without patch graft; for ruptured
aneurysm, abdominal aorta involving iliac vessels (common, hypogastric,
external)40.44 0.117 6836018060103

RUC33511Coronary artery bypass, vein only; two coronary venous grafts29.96
0.079 6924518053144

RUC35082Direct repair of aneurysm, pseudoaneurysm, or excision (partial or
total) and graft insertion, with or without patch graft; for ruptured
aneurysm, abdominal aorta38.44 0.098 7206018060103

RUC50236Nephrectomy with total ureterectomy and bladder cuff; through
separate incision24.82 0.074 561601905084

RUC47780Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and
gastrointestinal tract26.46 0.072 606751903083

RUC55873Cryosurgical ablation of the prostate (includes ultrasonic
guidance for interstitial cryosurgical probe placement)19.44 0.071
395602003013

RUC44202Laparoscopy, surgical; enterectomy, resection of small intestine,
single resection and anastomosis22.01 0.068 489752003053

RUC27487Revision of total knee arthroplasty, with or without allograft;
femoral and entire tibial component25.23 0.081 513602003064

RUC58951Resection of ovarian, tubal or primary peritoneal malignancy with
bilateral salpingo-oophorectomy and omentectomy; with total abdominal
hysterectomy, pelvic and limited para-aortic lymphadenectomy22.35 0.061
536752003362

RUC61510Craniectomy, trephination, bone flap craniotomy; for excision of
brain tumor, supratentorial, except meningioma28.41 0.083 6091052004074

Table 2. Comparison of Work

Lymphadenectomy

CPT Reference

38700

RVW = 8.2338740

RVW = 10.001 Code 38700 Suprahyoid lymphadenectomy (Level I neck dissection) can be compared with the work associated with code 38740

Axillary lymphadenectomy; superficial in the following ways:

- Both operations are indicated for the removal of microscopic lymph node metastases.
- Both procedures involve removal of lymph tissue with the preservation of major neurovascular structures. The axillary vein, thoracodorsal nerve and long thoracic nerves are at risk with axillary dissection, while the far more fragile marginal branch of the facial nerve, cranial nerves V and XII, external carotid, and retrofacial veins are at risk with the suprahyoid dissection. Additionally, the suprahyoid region involves a higher degree of anatomical complexity and morbidity, resulting in a longer procedure
- Post-procedural facility/office visits require attention to wound management, pathological findings, and further non-surgical treatment planning and counseling.
- Incision planning is of greater importance with 38700, as it is essential for aesthetic and functional outcome.

38720

RVW = 13.5938745

RVW = 13.08

15732

RVW = 17.81 Code 38720 Cervical lymphadenectomy (complete) can be compared with the work associated with 38745 Axillary lymphadenectomy; complete in the following ways:

- Both operations are indicated for the removal of bulky and microscopic lymph node metastases.
- Both procedures involve removal of lymph tissue with the preservation of major neurovascular structures, however, 38720 carries much greater risk for morbidity (eg, injury to cranial nerves, phrenic nerve, brachial plexus, massive hemorrhage, airway obstruction, stroke, blindness, and chyle fistula).
- Code 38720 requires more post-procedure facility/office visits for wound management, shoulder functional assessment and physical therapy, pathological findings, and further non-surgical treatment planning and counseling.
- Patients that undergo 38720 typically have undergone concurrent chemoradiation, with a reported risk of wound complications of over 70

percent. Axillary node dissections are performed mainly for breast cancer and melanoma, neither of which are typically treated with preoperative concurrent chemoradiation, and can be expected to have a lower complication rate.

- Incision planning is of greater importance with 38720, as it is essential for aesthetic outcome.

Codes 38720 and 15732 Muscle, myocutaneous, or fasciocutaneous flap; head and neck have very similar intra-time and number of visits, however, the intensity/level of work is greater for 38720 because identification and preservation of critical neurovascular structures, as well as the cancer care component, is greater.

38724

RVW = 14.5238745

RVW = 13.08

43633

RVW = 23.07As with code 38720, code 38724 Cervical lymphadenectomy (modified radical neck dissection) can be compared with the work associated with 38745 Axillary lymphadenectomy; complete in the following ways:

- Both operations are indicated for the removal of bulky and microscopic lymph node metastases.
- Both procedures involve removal of lymph tissue with the preservation of major neurovascular structures, however, 38724 carries much greater risk for morbidity (eg, injury to cranial nerves, phrenic nerve, brachial plexus, massive hemorrhage, airway obstruction, stroke, blindness, and chyle fistula).
- Code 38724 requires more post-procedure facility/office visits for wound management, shoulder functional assessment and physical therapy, pathological findings, and further non-surgical treatment planning and counseling.
- Patients that undergo 38724 typically need concurrent chemoradiation pre- or post-operatively+/-, with a reported risk of wound complications of over 70 percent. Axillary node dissections are performed mainly for breast cancer and melanoma, neither of which are typically treated with preoperative concurrent chemoradiation, and can be expected to have a lower complication rate.
- Incision planning is of greater importance with 38724, as it is essential for aesthetic outcome.
- Additionally, 38724 includes sparing cranial nerve XI which is more technically demanding in terms of identification and dissection, adding time and complexity to the operation. Variations of this procedure

also typically include the additional work of sparing the sternocleidomastoid muscle and the internal jugular vein, which add additional time and complexity.

Codes 38724 and 43633 Gastrectomy, partial, distal; with Roux-en-Y reconstruction have very similar intra-time and number of visits. Although 43633 includes risk of anastomotic leak and abscess, the technical demands of the dissection are less with respect to exposure and preservation of fine structures.

38700 Suprahyoid lymphadenectomy

Typical Patient: A 65-year-old man presents with an ulcerative lesion of the right lower lip. Physical examination shows a 1.5 cm lesion, confined to the mucosal surface of the right lower lip that does not approach the vermilion border, mid-line or oral commissure. Palpation of the neck revealed no cervical adenopathy. Biopsy of the lesion showed squamous cell carcinoma.

Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a flap is elevated in the upper cervical region. The lymph nodes and submandibular gland of the right Level I are removed and the wound is closed. Post-operative hospital and office visits are conducted as necessary during the 90-day global period to assure that adequate healing has occurred, the patient is able to maintain his nutrition, and no airway problem develops.

38720 Cervical lymphadenectomy (complete)

Typical Patient: A 64-year-old man presents with a 7 cm hypomobile lymph node in left side of neck, Level II. Examination of the upper aerodigestive tract reveals an exophytic lesion involving the left tonsil, which is 2 cm in diameter. The patient is clinically staged T1N3 squamous cell carcinoma of the left tonsil. He received definitive radiation and has a residual neck mass.

Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a radical neck dissection is performed with sacrifice of the sternocleidomastoid

muscle, internal jugular vein, cranial nerve XI, and the lymph nodes in Levels I-V. Post-operative hospital and office visits are conducted as necessary during the 90-day global period to assure that adequate healing has occurred, the patient is able to maintain his nutrition, and no airway problem develops.

38724 Cervical lymphadenectomy (modified radical neck dissection)

Typical Patient: A 45-year-old man with previously excised melanoma of the left neck now presents with a 2 cm neck mass in left Level III. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a modified radical neck dissection is performed with preservation of the sternocleidomastoid muscle and internal jugular vein, with complete dissection and preservation of the spinal accessory nerve. The lymph node stations I-V are removed. Post-operative hospital and office visits are conducted as necessary during the 90-day global period to assure that adequate healing has occurred and monitor shoulder function.

CPT	DESCRIPTOR	2005 RVW	GLOB
42890	Limited pharyngectomy	12.92	090
42892	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls	15.81	090
42894	Resection of pharyngeal wall requiring closure with myocutaneous flap	22.85	090

The American Head and Neck Society (AHNS) believes that the physician work RVUs for the pharyngectomy CPT codes shown above are misvalued. The work RVUs for these codes are Harvard-based and have never been reviewed by the RUC. Our recommended work RVUs are presented in Attachment A.

Table 1 below presents the physician time and visit pattern for these pharyngectomy procedures and many other RUC-reviewed procedures with similar time and visit patterns. The table is sorted first by intra-time and then by total time. As seen in this table, most codes have significantly higher work RVUs (RVWs) than the pharyngectomy codes, even though the time and visit pattern may be similar or greater. Another measure often used for comparison of physician work is the intra-work per unit time (IWPUT), which is shown for all codes in the table. An examination of these data show how the IWPUT values for the pharyngectomy procedures are significantly less than the other procedures presented. Table 2 presents a clinical comparison of work between each of the pharyngectomy codes and a RUC-reviewed reference service. Following this table, a typical patient vignette is provided for each pharyngectomy procedure.

Table 1. IWPUT and RUC database information for selected services (misvalued codes are highlighted)

Time Source	CPT	Long	2005 RVW	IWPUT	TOTAL TIME	Pre min	Intra min	Imm-SD min	LOS	OV's
RUC	34203	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision	16.48	0.075	397	75	108	30	5	3
RUC	57280	Colpopexy, abdominal approach	15.02	0.054	411	60	115	45	5	2
RUC	36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	13.98	0.084	253	25	120	15	2	2
RUC	61793	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions	17.21	0.103	305	85	120	18	1	2
RUC	58740	Lysis of adhesions (salpingolysis, ovariolysis)	13.98	0.060	359	68	120	33	3	2
RUC	23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	13.28	0.054	365	45	120	30	2	5
RUC	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	14.59	0.063	378	85	120	30	3	3
RUC	63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace	19.38	0.102	383	90	120	30	3	3
RUC	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	15.22	0.062	389	60	120	40	5	2
RUC	63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar	17.44	0.081	395	83	120	30	4	3

RUC	44160	Colectomy, partial, with removal of terminal ileum with ileocolostomy	18.59	0.058	497	63	120	45	7	3
RUC	43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)	20.54	0.076	498	90	120	30	6	3
RUC	43501	Gastrotomy; with suture repair of bleeding ulcer	20.01	0.051	506	60	120	30	7	3
Hvd	42890	Limited pharyngectomy	12.92	0.036	420	53	122	25	8	4
RUC	35221	Repair blood vessel, direct; intra-abdominal	24.35	0.087	496	53	125	45	7	2
RUC	47760	Anastomosis, of extrahepatic biliary ducts and gastrointestinal tract	25.81	0.097	557	75	130	45	8	3
Hvd	42892	Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls	15.81	0.028	533	55	133	27	12	4
RUC	50715	Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis	18.87	0.076	434	60	135	45	6	3
RUC	35301	Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision	18.67	0.077	416	90	144	40	4	2
RUC	54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	15.48	0.065	364	50	145	30	2	3
RUC	19318	Reduction mammoplasty	15.60	0.071	336	60	150	30	1	4
RUC	35656	Bypass graft, with other than vein; femoral-popliteal	19.50	0.075	439	90	150	30	6	2
RUC	34802	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)	22.97	0.100	448	135	150	40	3	2
RUC	15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	17.89	0.060	450	60	150	30	7	4
RUC	63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical	19.32	0.073	451	90	150	38	4	3
RUC	35151	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery	22.61	0.093	456	100	150	30	5	3
RUC	27486	Revision of total knee arthroplasty, with or without allograft; one component	19.24	0.068	463	60	150	30	6	4
RUC	35351	Thromboendarterectomy, with or without patch graft; iliac	22.97	0.091	464	90	150	30	5	2
RUC	35665	Bypass graft, with other than vein; iliofemoral	20.97	0.080	464	100	150	30	5	3
RUC	15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)	17.81	0.055	474	60	150	30	6	4
RUC	44140	Colectomy, partial; with anastomosis	20.97	0.072	502	90	150	40	7	3
RUC	44640	Closure of intestinal cutaneous fistula	21.62	0.065	524	60	150	30	8	2
RUC	32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple	21.97	0.061	577	90	150	45	7	3
RUC	33430	Replacement, mitral valve, with cardiopulmonary bypass	33.45	0.105	571	43	220	60	7	3
RUC	35631	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal	33.95	0.101	609	110	225	38	6	3

RUC	47120	Hepatectomy, resection of liver; partial lobectomy	35.45	0.079	727	75	225	30	9	4
Hvd	42894	Resection of pharyngeal wall requiring closure with myocutaneous flap	22.85	0.038	696	62	231	32	14	5
RUC	50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	23.96	0.071	484	60	240	30	4	2
RUC	33535	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts	34.45	0.106	548	40	240	60	4	5
RUC	33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	34.95	0.099	567	40	240	60	7	4
RUC	27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	28.48	0.074	608	90	240	40	8	3
RUC	58952	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)	24.97	0.051	660	60	240	60	9	3

Table 2. Comparison of Work

CPT	Key Reference	
42890 RVW = 12.92	34203 RVW = 16.48 43501 RVW = 20.01	<p>The work associated with 42890 <i>Limited pharyngectomy</i> is more complex than 34203 <i>Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision</i> or 43501 <i>Gastrotomy; with suture repair of bleeding ulcer</i> in the following ways:</p> <ul style="list-style-type: none"> • Nerve and vascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Work is done in a contaminated field (saliva) which potentially complicates wound healing and postoperative followup. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck.

<p>42892 RVW = 15.81</p>	<p>44140 RVW = 20.97</p>	<p>The work associated with 42892 <u>Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls</u> is of similar complexity to 44140 <u>Colectomy, partial; with anastomosis</u> in the following ways:</p> <ul style="list-style-type: none"> • A portion of the alimentary tract is resected and reanastomosed • Work is done in contaminated fields which potentially complicates wound healing and postoperative followup, necessitating meticulous, water-tight suturing techniques. <p>Additional complexity exists in the following ways:</p> <ul style="list-style-type: none"> • Nerve and vascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck.
<p>42894 RVW = 22.85</p>	<p>47120 RVW = 35.45</p>	<p>The work associated with 42894 <u>Resection of pharyngeal wall requiring closure with myocutaneous flap</u> is of similar complexity to 47120 <u>Hepatectomy, resection of liver; partial lobectomy</u> in the following ways:</p> <ul style="list-style-type: none"> • A large portion of an organ of the alimentary tract is resected • Work is done in contaminated fields which potentially complicates wound healing and postoperative followup, necessitating meticulous, water-tight suturing techniques. • The potential for significant bleeding exists. <p>Additional complexity exists in the following ways:</p> <ul style="list-style-type: none"> • Nerve and vascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck.

42890 Limited Pharyngectomy

Typical Patient: A 63-year-old man with a history of tobacco and alcohol abuse presents with a biopsy-proven squamous carcinoma of the posterior pharyngeal wall, measuring 1.5 cm in greatest dimension and its superior limit is at approximately the level of the tip of the epiglottis. He complains of mild throat pain, but denies any dysphagia, hoarseness or weight loss. He has no evidence of cervical metastasis by clinical exam and CT scan. Chest x-ray is negative for pulmonary metastases. Preoperatively, once a decision has been made to operate, the surgeon reviews pathology and imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a skin incision is made over the mid portion of the thyroid cartilage and extending to one side of the neck, followed by separation of the laryngopharyngeal complex from the great vessels and soft tissues of the neck with preservation of near neural structures. The pharynx is entered, and a portion of the posterior pharyngeal wall is resected with adequate surgical margins. A water-tight closure of the

pharyngotomy and a temporary tracheostomy (billed separately) is performed and NG tube and drains are placed. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred, that the patient is able to maintain his nutrition, and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

42892 Resection of lateral pharyngeal wall or pyriform sinus, direct closure by advancement of lateral and posterior pharyngeal walls

Typical Patient: A 67-year-old man with a history of tobacco and alcohol abuse presents with a squamous carcinoma limited to the posterior and left lateral wall of the hypopharynx. There is no evidence of cervical metastasis by clinical exam and CT scan. Chest x-ray is negative for pulmonary metastases. Preoperatively, once a decision has been made to operate, the surgeon reviews pathology and imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a skin incision is made over the thyroid cartilage and ipsilateral neck. The laryngopharyngeal structures are separated from the great vessels and surrounding soft tissues of the neck with preservation of neural structures close by. A portion of the thyroid ala is resected on the ipsilateral side to provide access to the pharynx. The pharynx is entered, and the tumor is resected with adequate surgical margins. Primary closure is performed with local advancement flaps. A temporary tracheostomy (billed separately) is performed and NG tube and drains are placed. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred, that the patient is able to maintain his nutrition, and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

42894 Resection of pharyngeal wall requiring closure with myocutaneous flap.

Typical Patient: A 55-year-old man, with a history of tobacco use and alcohol consumption, presents with cancer involving the lateral pharyngeal wall and lateral base of tongue. There is no evidence of cervical metastasis by clinical exam and CT scan. Preoperatively, once a decision has been made to perform a pharyngectomy, the surgeon reviews pathology and imaging studies and discusses possible reconstructive options with a reconstructive surgeon. An operative approach is planned. The surgeon discusses the procedure with the patient, and obtains informed consent. At operation, a tracheotomy and neck dissection is performed (billed separately). Access requires a mandibulotomy and lip split. A combined trans-oral, trans-cervical resection is completed. [The reconstructive surgeon enters and does the reconstruction (separately billable).] Drains are inserted and the wound closed, as appropriate. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred, that the patient is able to maintain his nutrition, and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

CPT	DESCRIPTOR	2005 RVW	GLOB
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	8.75	090
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)	14.29	090
42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap	24.25	090

The American Head and Neck Society (AHNS) believes that the physician work RVUs for the radical resection of tonsil CPT codes shown above are misvalued. The work RVUs for these codes are Harvard-based and have never been reviewed by the RUC. Our recommended work RVUs are presented in Attachment A.

Table 1 below presents the physician time and visit pattern for these radical resection of tonsil procedures and many other RUC-reviewed procedures with similar time and visit patterns. The table is sorted first by intra-time and then by total time. As seen in this table, most codes have significantly higher work RVUs (RVWs) than the radical resection of tonsil codes, even though the time and visit pattern may be similar or greater. Another measure often used for comparison of physician work is the intra-work per unit time (IWPUT) value, which is shown for all codes in the table. An examination of these data show how the IWPUT values for the radical resection of tonsil procedures are significantly less than the other procedures presented. Table 2 presents a clinical comparison of work between each of the radical resection of tonsil codes and a RUC-reviewed reference service. Following this table, a typical patient vignette is provided for each radical resection of tonsil procedure.

Table 1. IWPUT and RUC database information for selected services (misvalued codes are highlighted)

Time Source	CPT	Long	2005 RVW	IWPUT	TOTAL TIME	Pre min	Intra min	Imm-SD min	LOS	OV's
RUC	49560	Repair initial incisional or ventral hernia; reducible	11.55	0.091	221	45	90	30	1	2
RUC	53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	9.44	0.064	241	60	90	45	0	2
RUC	55859	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	12.50	0.095	249	50	90	0	0	3
RUC	65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	14.87	0.107	288	40	90	20	0	6
RUC	28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	10.56	0.058	297	75	90	30	1	4
RUC	49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	11.66	0.064	300	60	90	30	3	2
RUC	63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)	11.98	0.057	338	75	90	30	3	3
RUC	62223	Creation of shunt; ventriculo-peritoneal, -pleural, other terminus	12.85	0.063	353	90	90	30	3	3
RUC	47605	Cholecystectomy; with cholangiography	14.67	0.075	359	75	90	30	4	2
RUC	61751	Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic	17.59	0.106	391	128	90	30	3	3

		resonance guidance								
Hvd	42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	8.75	0.040	281	49	91	22	3	3
RUC	49565	Repair recurrent incisional or ventral hernia; reducible	11.55	0.058	298	45	100	30	3	2
RUC	35226	Repair blood vessel, direct; lower extremity	14.48	0.084	313	60	100	30	3	2
RUC	49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	14.23	0.074	328	45	100	30	4	2
RUC	32100	Thoracotomy, major; with exploration and biopsy	15.22	0.066	418	90	100	86	4	2
RUC	35371	Thromboendarterectomy, with or without patch graft; common femoral	14.70	0.085	320	75	103	30	3	2
RUC	60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy	10.86	0.068	263	60	105	0	0	2
RUC	34203	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision	16.48	0.075	397	75	108	30	5	3
RUC	57280	Colpopexy, abdominal approach	15.02	0.054	411	60	115	45	5	2
RUC	36830	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)	11.98	0.081	215	55	120	25	0	1
RUC	36833	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	11.93	0.079	225	45	120	45	0	1
RUC	33249	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator	14.21	0.091	249	60	120	0	0	3
RUC	36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	13.98	0.084	253	25	120	15	2	2
RUC	61793	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions	17.21	0.103	305	85	120	18	1	2
RUC	35372	Thromboendarterectomy, with or without patch graft; deep (profunda) femoral	17.97	0.099	342	80	120	30	3	2
RUC	49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	14.38	0.063	348	45	120	30	4	2
RUC	58740	Lysis of adhesions (salpingolysis, ovariolysis)	13.98	0.060	359	68	120	33	3	2
RUC	23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	13.28	0.054	365	45	120	30	2	5
RUC	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	14.59	0.063	378	85	120	30	3	3
RUC	63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace	19.38	0.102	383	90	120	30	3	3
RUC	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	15.22	0.062	389	60	120	40	5	2
RUC	63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar	17.44	0.081	395	83	120	30	4	3
RUC	44200	Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)	14.42	0.055	400	100	120	30	5	2
RUC	35879	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty	15.98	0.065	404	75	120	25	5	2
RUC	35661	Bypass graft, with other than vein; femoral-femoral	18.97	0.086	424	90	120	30	5	3
RUC	50715	Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis	18.87	0.076	434	60	135	45	6	3

Hvd	42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)	14.29	0.029	485	54	136	26	10	4
RUC	35301	Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision	18.67	0.077	416	90	144	40	4	2
RUC	54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	15.48	0.065	364	50	145	30	2	3
RUC	19318	Reduction mammoplasty	15.60	0.071	336	60	150	30	1	4
RUC	60271	Thyroidectomy, including substernal thyroid; cervical approach	16.80	0.071	363	60	150	30	3	2
RUC	43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	17.22	0.070	400	100	150	30	3	2
RUC	35141	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial)	19.97	0.084	412	90	150	30	4	2
RUC	24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)	18.46	0.071	429	60	150	30	3	5
RUC	58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube (s), with or without removal of ovary(s)	21.56	0.088	435	60	150	45	5	2
RUC	35656	Bypass graft, with other than vein; femoral-popliteal	19.50	0.075	439	90	150	30	6	2
RUC	15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	17.89	0.060	450	60	150	30	7	4
RUC	63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical	19.32	0.073	451	90	150	38	4	3
RUC	35666	Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery	22.16	0.086	473	90	150	30	6	3
RUC	15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)	17.81	0.055	474	60	150	30	6	4
RUC	44140	Colectomy, partial; with anastomosis	20.97	0.072	502	90	150	40	7	3
RUC	33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	32.95	0.102	571	43	220	60	7	3
RUC	33430	Replacement, mitral valve, with cardiopulmonary bypass	33.45	0.105	571	43	220	60	7	3
RUC	35631	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal	33.95	0.101	609	110	225	38	6	3
RUC	33535	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts	34.45	0.106	548	40	240	60	4	5
RUC	33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	34.95	0.099	567	40	240	60	7	4
RUC	58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	28.81	0.076	601	75	240	45	7	3
RUC	27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	28.48	0.074	608	90	240	40	8	3
RUC	61512	Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	35.04	0.100	626	105	240	40	7	3

RUC	58952	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)	24.97	0.051	660	60	240	60	9	3
Hvd	42845	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap	24.25	0.037	752	66	244	35	13	5
RUC	33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp	36.20	0.096	587	40	260	60	7	4
RUC	33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	39.94	0.109	621	43	270	60	7	3
RUC	33536	Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts	37.44	0.103	583	40	275	60	4	5

Table 2. Comparison of Work

CPT	Key Reference	
42842 RVW = 8.75	53850 RVW = 9.43	<p>The work associated 42842 <i>Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure</i> is similar to that of 53850 <i>Transurethral destruction of prostate tissue; by microwave thermotherapy</i>:</p> <ul style="list-style-type: none"> • Both involve significant use of cautery devices to remove tissue. • No closure is performed; tissues are allowed to heal secondarily. <p>The oropharynx of 42842 has additional complexity primarily with airway management and swallowing function as patients' airways are often affected by both tumors and surgical procedures in this region.</p>
42844 RVW = 14.29	15732 RVW = 17.81	<p>The work of 42844 <i>Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)</i> has within its description a surgical defect requiring a muscle or myomucosal flap for closure in addition to a complicated resection of tissue, but is valued less than 15732 <i>Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)</i> which is itself a muscle flap of the head and neck. Code 42844 is more complex than the flap procedure alone for the following reasons:</p> <ul style="list-style-type: none"> • Work is done in contaminated fields which potentially complicates wound healing and postoperative followup, necessitating meticulous, water-tight suturing techniques. • Nerve and vascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved, if not involved with tumor. Surgical changes to these structures yield specific increased risk of dysfunction in regard to oral intake as well as speech/communication, thereby requiring enhanced monitoring of rehabilitation during the postoperative period. • Airway management is critical as patients' airways are often

		affected by both tumors and surgical procedures in this region.
42845 RVW = 24.25	58210 RVW = 28.81 61512 RVW = 35.04	<p>Code 42845 <u>Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap</u> is more complicated than 58210 <u>Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)</u> for the following reasons:</p> <ul style="list-style-type: none"> • Work is done in contaminated fields which potentially complicates wound healing and postoperative followup, necessitating meticulous, water-tight suturing techniques. • Nerve and vascular structures critical for speech and swallowing function and perfusion of the neck, head and brain must be dissected and preserved if not involved with tumor. Surgical changes to these structures yield specific increased risk of dysfunction in regard to oral intake as well as speech/communication, thereby requiring enhanced monitoring of rehabilitation during the postoperative period. • Airway management is critical as patients' airways are often affected by both tumors and surgical procedures in this region. • Cosmetic considerations are more complex given patients' perception of body image with scars on the face and neck • Splitting the mandible requires monitoring for preservation/restoration of dental integrity <p>Code 42845 can also be compared with 61512, <u>Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial</u> The mandibulotomy required for 42845 is similar to the craniotomy for 61512.</p> <ul style="list-style-type: none"> • A water-tight closure is required (eg, dural closure) • A tumor involving critical neurovascular tissues is resected (eg, meningioma). • Bone is often resected (eg, retromolar trigone tumors) <p>Additionally, surgical changes to these structures yield specific increased risk of dysfunction in regard to oral intake as well as speech/communication, thereby requiring enhanced monitoring of rehabilitation during the postoperative period.</p>

42842 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure

Typical Patient: A 62-year-old man presents with a small squamous cell carcinoma involving his tonsil and anterior tonsillar pillar. The widest dimension of the tumor is just over 2.0 cm. It does not appear to be deeply invasive of the pharyngeal constrictor muscles. Preoperatively, once a decision has been made to operate, the surgeon reviews pathology and imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At

operation, the lesion is resected transorally in its entirety with adequate normal mucosal and deep margins. Negative margins are confirmed with intraoperative frozen section review by pathologist and surgeon. The defect is allowed to heal secondarily without flap reconstruction. An NG tube is placed. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

42844 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (e.g. tongue buccal)

Typical Patient: A 62-year-old man with a history of radiation therapy for a T1N0M0 squamous cell carcinoma of the RMT presents with a biopsy-proven recurrent invasive squamous cell carcinoma. Preoperatively, once a decision has been made to operate, the surgeon reviews pathology and imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a peroral approach is obtained. The tumor is resected with adequate margins checked by frozen section. A local flap is used to reconstruct the area of the exposed mandible and sewn into place. A tracheostomy (billed separately) is performed and NG tube and drains are placed. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

42845 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap

Typical Patient: A 62-year-old man, who previously underwent combination radiation and chemotherapy for a large tonsillar squamous cell carcinoma after a neck dissection, presents with pain and dysphagia secondary to a 4.5 cm diameter recurrent cancer. A CT scan shows a localized tumor in the tonsillar fossa and a PET scan shows no other lesions. Preoperatively, once a decision has been made to operate, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation using an upper cervical incision and median mandibulotomy for access, the carotid artery, vagus and hypoglossal nerves are dissected and preserved. The tumor is removed with adequate margin checked by frozen section. After the reconstructive surgeon has brought the flap to the region (billed separately by the reconstructive surgeon), the flap is inset in a manner to promote primary healing and restore swallowing function. A tracheostomy is performed (billed separately) and NG tube and drains are placed. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

CPT	DESCRIPTOR	2005 RVW	GLOB
42120	Resection of palate or extensive resection of lesion	6.16	090

The American Head and Neck Society (AHNS) believes that the physician work RVU for 42120 is misvalued as discussed below. Our recommended work RVU is presented in Attachment A.

During the first 5-year-review in 1995, the American Academy of Otolaryngology – Head and Neck Surgery had commented that the RVW for 42120 was undervalued. However, the RUC rejected this comment and only compared the AAO-HNS survey data with Harvard data. The RUC did not consider that this code was significantly undervalued relative to many other codes on the MFS.

Table 1 below presents the physician time and visit pattern for 42120 and a several high volume RUC-reviewed procedures with similar time and visit patterns. The table is sorted first by intra-time and then by total time. Another measure often used for comparison of physician work is the intra-work per unit time (IWPUT) value, which is shown for all codes in the table. An examination of these data show how the IWPUT for 42120 is significantly less than the other procedures presented and very near zero. Table 2 presents a clinical comparison of work between 42120 and a RUC-reviewed reference service. Following this table, a typical patient vignette is provided for 42120.

Table 1. IWPUT and RUC database information for selected services (misvalued code is highlighted)

Time Source	CPT	Long	2005 RVW	IWPUT	TOTAL TIME	Pre min	Intra min	Imm-SD min	LOS	OV's
RUC	66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	10.21	0.132	190	44	50	20	0	4
RUC	53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	9.87	0.096	232	60	58	45	0	3
RUC	49505	Repair initial inguinal hernia, age 5 years or over; reducible	7.59	0.077	173	37	60	20	1	2
RUC	29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)	8.24	0.065	222	48	60	20	1	4
RUC	38740	Axillary lymphadenectomy; superficial	10.01	0.094	229	60	60	30	1	3
RUC	44950	Appendectomy;	9.99	0.078	247	50	60	25	3	2
RUC	58260	Vaginal hysterectomy, for uterus 250 grams or less;	12.96	0.104	296	60	60	30	3	2
RUC	47100	Biopsy of liver, wedge	11.65	0.066	330	75	60	30	4	3
Hvd	42120	Resection of palate or extensive resection of lesion	6.16	0.005	289	51	73	22	3	3
RUC	50590	Lithotripsy, extracorporeal shock wave	9.08	0.068	224	45	80	30	0	3
RUC	47600	Cholecystectomy;	13.56	0.070	349	75	80	30	4	2
RUC	49560	Repair initial incisional or ventral hernia; reducible	11.55	0.091	221	45	90	30	1	2
RUC	53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	9.44	0.064	241	60	90	45	0	2

RUC	55859	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	12.50	0.095	249	50	90	0	0	3
RUC	49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	11.95	0.081	258	45	90	30	2	2
RUC	65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	14.87	0.107	288	40	90	20	0	6

Table 2. Work Comparison

Palatectomy CPT	Key Reference	
42120 RVW = 6.16	49505 RVW = 7.59	Compared with 49505 <i>Repair initial inguinal hernia, age 5 years or over; reducible</i> , the preoperative work is greater for 42120 <i>Resection of palate or extensive resection of lesion</i> due to multiple imaging studies and involvement of a prosthetic. Intraoperatively, decision making re: cancer clearance for 42120 is greater than for 49505. Operative time is similar, but access to the mouth/palate is more complex/intense. Postoperatively, speech and swallowing may be disrupted or altered, due to pain, and close monitoring is necessary. Additionally, the patient may require adjuvant therapy postoperatively for extensive lesions.

42120 Resection of palate or extensive resection of lesion

Typical Patient: A 65-year-old man presents with a non-healing painful lesion of the midportion of the right side of the hard palate. Exam demonstrates a 2 cm lesion which is biopsy-proven adenocarcinoma.

Preoperatively, once a decision to operate has been made, the surgeon reviews pathology and imaging studies, discusses the procedure with the patient, and obtains informed consent. At operation, the lesion is excised with a circumferential margin of normal tissue, elevating the periosteum off the palate as a part of the resection specimen. The surface of the cortical palatal bone is removed with a rotary burr to provide a favorable surface granulation and healing by secondary intention. A pressure dressing is sutured into place over the skin graft and NG tube is placed. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

CPT Code	DESCRIPTOR	2005 RVW	GLOB
41120	Glossectomy; less than one-half tongue	9.76	090
41130	Glossectomy; hemiglossectomy	11.13	090
41135	Glossectomy; partial, with unilateral radical neck dissection	23.06	090
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	25.46	090
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	30.01	090
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	23.01	090
41153	Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection	23.73	090
41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	27.68	090

The American Head and Neck Society (AHNS) believes that the physician work RVUs for the eight glossectomy CPT codes shown above are misvalued as discussed below. Our recommended work RVUs are presented in Attachment A.

During the first 5-year-review in 1995, the American Academy of Otolaryngology – Head and Neck Surgery had commented that the work RVUs for four glossectomy codes were undervalued. The RUC review of the Academy recommendations resulted in a change in work RVUs for three of the codes (41135, 41150, 41155). The work RVUs for the other five glossectomy codes are still based on Harvard data.

The AHNS believes that all eight of these infrequently performed procedures suffer rank order anomalies within their family and relative to other codes in the MFS with similar intra- and total physician work. As an example of intra-family anomalies, 41153 requires more intra-operative work than 41150, and total work is much closer to 41155, however, the work RVU for 41153 is just slightly higher than 41150. The AHNS also believes that the difference in work RVUs between 41120 and 41130 does not accurately reflect the difference in intra-operative work and post-operative hospital work. Another example of a family anomaly is seen in the comparison of the total work for 41145 and 41155. Although the intra-operative time is greater and the length of stay similar or greater for 41155 than for 41145, the work RVU is less.

Table 1 below presents the physician time and visit pattern for these eight glossectomy procedures and a significant number of RUC-reviewed procedures with similar time and visit patterns. The table is sorted first by intra-time and then by total time. As seen in this table, most codes have significantly higher work RVUs (RVWs), than the glossectomy codes, even though the time and visit pattern may be similar or greater. Another measure often used for comparison of physician work is the intra-work per unit time (IWPUT), which is shown for all codes in the table. An examination of these data show how the IWPUT for the glossectomy procedures is significantly less than the other procedures presented. Table 2 presents a clinical comparison of work between each of the glossectomy codes and a RUC-reviewed reference service. Following this table, a typical patient vignette is provided for each glossectomy procedure.

Table 1. IWPUT and RUC database information for selected services (misvalued codes are highlighted)

Time Source	CPT	Long	2005 RVW	IWPUT	TOTAL					

					TIME	Pre min	Intra min	Imm-SD min	LOS	OV's
RUC	36831	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	7.99	0.093	163	53	60	35	0	1
RUC	67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	6.25	0.057	171	30	60	20	0	3
RUC	49505	Repair initial inguinal hernia, age 5 years or over; reducible	7.59	0.077	173	37	60	20	1	2
RUC	49520	Repair recurrent inguinal hernia, any age; reducible	9.62	0.106	184	45	60	23	1	2
RUC	49525	Repair inguinal hernia, sliding, any age	8.56	0.086	191	45	60	30	1	2
RUC	66825	Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)	8.22	0.070	216	45	60	20	0	5
RUC	29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)	8.24	0.065	222	48	60	20	1	4
RUC	38740	Axillary lymphadenectomy; superficial	10.01	0.094	229	60	60	30	1	3
RUC	44950	Appendectomy;	9.99	0.078	247	50	60	25	3	2
RUC	66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally	13.48	0.129	266	40	60	15	1	5
RUC	34825	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel	11.98	0.091	293	80	60	30	3	2
RUC	58260	Vaginal hysterectomy, for uterus 250 grams or less;	12.96	0.104	296	60	60	30	3	2
RUC	47100	Biopsy of liver, wedge	11.65	0.066	330	75	60	30	4	3
RUC	66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	12.14	0.060	387	60	60	60	0	9
RUC	44310	Ileostomy or jejunostomy, non-tube (separate procedure)	15.93	0.110	367	75	63	30	6	2
RUC	49507	Repair initial inguinal hernia, age 5 years or over; incarcerated or strangulated	9.56	0.072	236	45	68	30	2	2
RUC	38760	Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)	12.93	0.122	239	60	70	30	1	3
RUC	44970	Laparoscopy, surgical, appendectomy	8.69	0.090	168	45	73	20	0	0
Hvd	41120	Glossectomy; less than one-half tongue	9.76	0.040	318	51	73	22	5	4
RUC	49553	Repair initial femoral hernia, any age; incarcerated or strangulated	9.43	0.063	243	45	75	30	2	2
RUC	43832	Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)	15.58	0.084	378	60	75	30	6	2
RUC	50590	Lithotripsy, extracorporeal shock wave	9.08	0.068	224	45	80	30	0	3
RUC	47600	Cholecystectomy;	13.56	0.070	349	75	80	30	4	2
Hvd	41130	Glossectomy; hemiglossectomy	11.13	0.056	318	51	82	22	5	4

RUC	44050	Reduction of volvulus, intussusception, internal hernia, by laparotomy	14.01	0.060	383	60	83	30	7	2
RUC	36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	10.48	0.091	190	45	90	40	0	1
RUC	49560	Repair initial incisional or ventral hernia; reducible	11.55	0.091	221	45	90	30	1	2
RUC	58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)	11.27	0.084	227	48	90	30	1	1
RUC	68720	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)	8.95	0.058	234	40	90	20	0	4
RUC	53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	9.44	0.064	241	60	90	45	0	2
RUC	49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	11.95	0.081	258	45	90	30	2	2
RUC	38745	Axillary lymphadenectomy; complete	13.08	0.094	267	58	90	25	1	3
RUC	60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	11.88	0.077	271	63	90	25	2	2
RUC	35206	Repair blood vessel, direct; upper extremity	13.23	0.088	277	50	90	25	3	2
RUC	29807	Arthroscopy, shoulder, surgical; repair of slap lesion	13.88	0.097	284	55	90	30	1	5
RUC	65750	Keratoplasty (corneal transplant); penetrating (in aphakia)	14.98	0.108	288	40	90	20	0	6
RUC	65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	14.87	0.107	288	40	90	20	0	6
RUC	28299	Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy	10.56	0.058	297	75	90	30	1	4
RUC	49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	11.66	0.064	300	60	90	30	3	2
RUC	65730	Keratoplasty (corneal transplant); penetrating (except in aphakia)	14.23	0.090	318	40	90	20	0	6
RUC	63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)	11.98	0.057	338	75	90	30	3	3
RUC	62223	Creation of shunt; ventriculo-peritoneal, -pleural, other terminus	12.85	0.063	353	90	90	30	3	3
RUC	38100	Splenectomy; total (separate procedure)	14.48	0.073	355	55	90	30	6	2
RUC	47605	Cholecystectomy; with cholangiography	14.67	0.075	359	75	90	30	4	2
RUC	44120	Enterectomy, resection of small intestine; single resection and anastomosis	16.97	0.093	379	60	90	30	6	2
RUC	61751	Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance	17.59	0.106	391	128	90	30	3	3
RUC	44604	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy	16.01	0.065	420	60	90	30	7	2
RUC	44320	Colostomy or skin level cecostomy; (separate procedure)	17.61	0.070	465	75	90	30	7	3
RUC	57284	Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse)	12.68	0.084	284	45	95	60	0	4

RUC	49565	Repair recurrent incisional or ventral hernia; reducible	11.55	0.058	298	45	100	30	3	2
RUC	35226	Repair blood vessel, direct; lower extremity	14.48	0.084	313	60	100	30	3	2
RUC	49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	14.23	0.074	328	45	100	30	4	2
RUC	35286	Repair blood vessel with graft other than vein; lower extremity	16.14	0.092	344	60	100	30	4	3
RUC	32100	Thoracotomy, major; with exploration and biopsy	15.22	0.066	418	90	100	86	4	2
RUC	35371	Thromboendarterectomy, with or without patch graft; common femoral	14.70	0.085	320	75	103	30	3	2
RUC	34203	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision	16.48	0.075	397	75	108	30	5	3
RUC	35301	Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision	18.67	0.077	416	90	144	40	4	2
RUC	35656	Bypass graft, with other than vein; femoral-popliteal	19.50	0.075	439	90	150	30	6	2
RUC	34802	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)	22.97	0.100	448	135	150	40	3	2
RUC	15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	17.89	0.060	450	60	150	30	7	4
RUC	63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical	19.32	0.073	451	90	150	38	4	3
RUC	35151	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery	22.61	0.093	456	100	150	30	5	3
RUC	27486	Revision of total knee arthroplasty, with or without allograft; one component	19.24	0.068	463	60	150	30	6	4
RUC	35351	Thromboendarterectomy, with or without patch graft; iliac	22.97	0.091	464	90	150	30	5	2
RUC	35665	Bypass graft, with other than vein; iliofemoral	20.97	0.080	464	100	150	30	5	3
RUC	35666	Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery	22.16	0.086	473	90	150	30	6	3
RUC	15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)	17.81	0.055	474	60	150	30	6	4
RUC	44140	Colectomy, partial; with anastomosis	20.97	0.072	502	90	150	40	7	3
RUC	43631	Gastrectomy, partial, distal; with gastroduodenostomy	22.56	0.079	507	75	150	30	8	3
RUC	32500	Removal of lung, other than total pneumonectomy; wedge resection, single or multiple	21.97	0.061	577	90	150	45	7	3
RUC	61313	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral	24.89	0.068	632	100	150	40	10	3
RUC	33510	Coronary artery bypass, vein only; single coronary venous graft	28.96	0.088	662	45	150	53	14	4
RUC	35876	Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft	16.97	0.065	395	60	155	30	5	2
RUC	33533	Coronary artery bypass, using arterial graft(s); single arterial graft	29.96	0.135	463	40	155	60	4	5
		Removal of lung, other than total pneumonectomy; single lobe								

RUC	32480	(lobectomy)	23.71	0.063	552	90	155	30	7	3
RUC	23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	21.07	0.079	443	60	165	30	4	4
RUC	44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	25.04	0.097	439	45	180	30	5	3
RUC	27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	21.14	0.069	485	75	180	30	6	3
RUC	27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	22.14	0.074	485	75	180	30	6	3
RUC	35654	Bypass graft, with other than vein; axillary-femoral-femoral	24.96	0.089	487	90	180	30	5	3
RUC	35571	Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels	24.02	0.083	493	80	180	30	6	3
RUC	50234	Nephrectomy with total ureterectomy and bladder cuff; through same incision	22.37	0.072	504	60	180	45	7	3
RUC	35587	In-situ vein bypass; popliteal-tibial, peroneal	24.71	0.085	506	93	180	30	6	3
RUC	50240	Nephrectomy, partial	21.97	0.055	595	75	180	60	9	4
RUC	45110	Proctectomy; complete, combined abdominoperineal, with colostomy	27.96	0.080	624	80	180	30	9	4
RUC	35103	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)	40.44	0.117	683	60	180	60	10	3
RUC	33511	Coronary artery bypass, vein only; two coronary venous grafts	29.96	0.079	692	45	180	53	14	4
RUC	35082	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	38.44	0.098	720	60	180	60	10	3
RUC	50236	Nephrectomy with total ureterectomy and bladder cuff; through separate incision	24.82	0.074	561	60	190	50	8	4
RUC	47780	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract	26.46	0.072	606	75	190	30	8	3
RUC	55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)	19.44	0.071	395	60	200	30	1	3
RUC	44202	Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis	22.01	0.068	489	75	200	30	5	3
RUC	27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	25.23	0.081	513	60	200	30	6	4
RUC	58951	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	22.35	0.061	536	75	200	33	6	2
RUC	61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	28.41	0.083	609	105	200	40	7	4
RUC	35081	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta	27.97	0.076	635	108	203	60	10	2

RUC	50546	Laparoscopy, surgical; nephrectomy, including partial ureterectomy	20.45	0.064	460	60	205	18	4	3
RUC	33534	Coronary artery bypass, using arterial graft(s); two coronary arterial grafts	32.15	0.113	513	40	205	60	4	5
RUC	33512	Coronary artery bypass, vein only; three coronary venous grafts	31.75	0.078	717	45	205	53	14	4
RUC	60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	26.95	0.091	476	60	210	30	4	3
RUC	33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	32.41	0.080	593	30	210	50	8	3
RUC	35646	Bypass graft, with other than vein; aortobifemoral	30.95	0.092	602	100	210	30	7	3
Hvd	41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	25.46	0.052	678	65	224	34	10	5
RUC	41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	23.01	0.041	690	90	210	35	10	5
RUC	44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	26.38	0.058	696	120	210	45	10	4
RUC	33513	Coronary artery bypass, vein only; four coronary venous grafts	31.95	0.077	722	45	210	53	14	4
RUC	33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	32.95	0.102	571	43	220	60	7	3
RUC	33430	Replacement, mitral valve, with cardiopulmonary bypass	33.45	0.105	571	43	220	60	7	3
RUC	35631	Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal	33.95	0.101	609	110	225	38	6	3
RUC	47120	Hepatectomy, resection of liver; partial lobectomy	35.45	0.079	727	75	225	30	9	4
RUC	33514	Coronary artery bypass, vein only; five coronary venous grafts	32.70	0.075	737	45	225	53	14	4
Hvd	41153	Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection	23.73	0.034	762	63	238	33	15	5
RUC	50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	23.96	0.071	484	60	240	30	4	2
RUC	33535	Coronary artery bypass, using arterial graft(s); three coronary arterial grafts	34.45	0.106	548	40	240	60	4	5
RUC	33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	34.95	0.099	567	40	240	60	7	4
RUC	58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	28.81	0.076	601	75	240	45	7	3
RUC	27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	28.48	0.074	608	90	240	40	8	3
RUC	61512	Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	35.04	0.100	626	105	240	40	7	3
RUC	61518	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull	37.26	0.104	665	110	240	40	7	4

RUC	35102	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels...	30.71	0.073	691	108	240	60	11	2
RUC	41135	Glossectomy; partial, with unilateral radical neck dissection	23.06	0.039	697	90	240	35	10	4
RUC	35566	Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels	26.88	0.054	689	90	258	40	11	3
RUC	33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)	37.44	0.101	587	40	260	60	7	4
RUC	33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary cusp	36.20	0.096	587	40	260	60	7	4
RUC	33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	39.94	0.109	621	43	270	60	7	3
RUC	61700	Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation	50.44	0.116	838	120	270	45	11	4
RUC	33536	Coronary artery bypass, using arterial graft(s); four or more coronary arterial grafts	37.44	0.103	583	40	275	60	4	5
Hvd	41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	30.01	0.050	806	68	283	35	16	7
RUC	58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	31.95	0.072	671	90	285	45	6	3
RUC	33860	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension;	37.94	0.079	712	60	300	70	8	3
RUC	33875	Descending thoracic aorta graft, with or without bypass	33.01	0.066	728	60	300	60	10	2
RUC	48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy	47.82	0.073	979	90	315	45	13	4
RUC	41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	27.68	0.040	813	90	320	37	11	5
RUC	33870	Transverse arch graft, with cardiopulmonary bypass	43.93	0.090	742	60	330	70	8	3
RUC	48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy	47.93	0.067	1013	90	345	45	13	4
RUC	33863	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction	44.93	0.085	772	60	360	70	8	3
RUC	21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	46.37	0.078	846	120	480	n/a	7	6
RUC	20955	Bone graft with microvascular anastomosis; fibula	39.15	0.062	864	100	480	n/a	9	6

Table 2. Comparison of Work

Glossectomy Code	Reference Code	
41120 RVW = 9.76	58260 RVW = 14.75	Both 41120 <i>Glossectomy; less than one-half tongue</i> and 58260 <i>Vaginal hysterectomy, for uterus 250 grams or less</i> are performed without making an external skin incision, and identification and dissection of adjacent neurovascular structures is necessary. In addition, the total procedure time is longer for 41120, and there is more postoperative work involved in monitoring the glossectomy patient for resumption of vital speech and swallowing functions. Postoperative work difference also exist when comparing benign with malignant diagnoses in that coordination of adjuvant therapy (radiation) is necessary and continued monitoring for recurrences within the 90 day global period.
41130 RVW = 11.13	58260 RVW = 14.75	Both 41130 <i>Glossectomy; hemiglossectomy</i> and 58260 <i>Vaginal hysterectomy, for uterus 250 grams or less</i> involve similar pre-operative evaluation. Both procedures are performed without making an external skin incision, and identification and dissection of adjacent neurovascular structures is necessary in both procedures. In addition, the total procedure time is longer for 41130, and there is more postoperative work involved in monitoring the glossectomy patient for resumption of vital speech and swallowing functions. Postoperative work difference also exist when comparing benign with malignant diagnoses in that coordination of adjuvant therapy (radiation) is necessary and continued monitoring for recurrences within the 90 day global period.
41135 RVW = 23.06	61512 RVW = 35.04	41135 <i>Glossectomy; partial, with unilateral radical neck dissection</i> is performed for cancer of the tongue, whereas 61512 <i>Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial</i> is performed for meningioma, a benign disease. Preoperative work is similar for both types of surgery, although decision making is more complex for a cancer diagnosis. The length of surgery in both cases is similar, and the technical demands of both procedures are also similar with major neurovascular structures at risk. Close monitoring (ie, ICU) may be required after both procedures, and the postoperative work for 41135 is greater as the surgeon monitors resumption of vital speech and swallowing functions, as well as drain care and shoulder function.

<p>41140 RVW = 25.46</p>	<p>47120 RVW = 35.45</p>	<p>Both 41140 <u>Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection</u> and 47120 <u>Hepatectomy, resection of liver; partial lobectomy</u> involve similar preoperative work and decision making. The length of these two procedures is similar, with nearly identical intraoperative time. Technically, 41140 is at least as demanding as 47120, with the need to dissect and identify vital neurovascular structures. Postoperative management following 41140 is more extensive than 47120, as there are continuing issues concerning airway management and the restoration of vital speech and swallowing function following 41140 that are not present following 47120.</p>
<p>41145 RVW = 30.01</p>	<p>61700 RVW = 50.44</p>	<p>CPT 41145 <u>Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection</u> is performed for cancer of the tongue, whereas 61700 <u>Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation</u> is performed for a non-malignant diagnosis. Pre-operative decision making and planning for cancer surgery of this magnitude is more complex than for CPT 61700. The procedure time for both surgeries is similar, and in both cases there is a need to identify and dissect major neurovascular structures, particularly the carotid artery. Following both of these procedures, close monitoring in an ICU setting is likely, and total length of stay for 41145 is longer. Post-operative management following 41145 is more extensive than 61700, as there are significant issues regarding airway management, drain management and restoration of vital speech, swallowing and shoulder function that do not exist following 61700 (unless paralysis has occurred as a result of the aneurysm).</p>
<p>41150 RVW = 23.01</p>	<p>35646 RVW = 30.95</p>	<p>CPT 41150 <u>Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection</u> is performed for oral cancer, whereas CPT 35646 <u>Bypass graft, with other than vein; aortobifemoral</u> is performed for vascular disease. The preoperative decision making for 41150 is more complex than 35646, with consideration of not only oncologic issues, but also appropriate restoration of function. Intraoperative time is similar for these two codes, and both surgical procedures have similar technical concerns regarding identification and dissection of vital neurovascular structures. Postoperative length of stay is longer for 41150, and postoperative management following 41150 is more complex, as there are issues concerning airway management and restoration of speech and swallowing function that do not exist following 35646.</p>

41153 RVW = 23.73	58210 RVW = 28.81	CPT 41153 <u>Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection</u> and CPT 58210 <u>Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)</u> are both performed for cancer, therefore the preoperative work and decision making are similar. The total time for 41153 is longer than for 58210. Technically, both surgeries involve a skin incision, and identification and dissection of important neurovascular structures. Postoperative length of stay is longer for 41153, resulting in more work for the surgeon. Postoperative management following 41153 is also more complex, as there are issues related to restoration of speech and swallowing function that are not applicable after 58210.
41155 RVW = 27.68	48153 RVW = 47.82	CPT 41155 <u>Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)</u> and 48153 <u>Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy</u> are both performed for cancer. The preoperative work in both cases involves extensive review of data including imaging studies, and extended discussion of both the procedure and other treatment options. In addition, the planning for 41155 must include provisions for reconstruction that often involves a separate surgical team, requiring significant coordination. Both procedures are long and technically demanding. Initial postoperative management following both procedures typically involves close observation in an ICU setting. Length of stay for the two procedures is similar, and both require significant work from the surgeon. While post-operative concerns following 48153 center on return of GI, biliary and pancreatic function, post-operative management following 41155 centers on restoration of equally vital speech and swallowing functions.

41120 Glossectomy; less than one-half of tongue

Typical Patient: A 57-year-old man presents with a 2 month history of an enlarging, painful “sore” on the left lateral border of the mobile tongue. He has a history of having smoked one pack of cigarettes daily for 40 years and consumes 3 beers daily. His medical history is significant for hypertension and atherosclerotic heart disease for which he underwent an angioplasty two years previously. He is on aspirin, beta blockers, and antihypertensive medication. A recent biopsy performed by an oral surgeon revealed epidermoid cancer. His CT scan of the neck was negative. Physical exam revealed a 1.8 cm tumor on the lateral border of the tongue (T1N0M0 Stage I carcinoma of the tongue). Preoperatively, once a decision has been made to perform a partial glossectomy, the surgeon reviews pathology and imaging studies to plan the operative approach, discusses the procedure with the patient, and obtains informed consent. At operation, a portion of the left side of the tongue measuring 2cm x 5cm is removed and the tongue is sutured in a standard fashion. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

41130 Hemiglossectomy

Typical Patient: A 57-year-old man presents with a 2 month history of an enlarging, painful “sore” on the left lateral border of the mobile tongue. He has a history of having smoked one pack of cigarettes daily for 40 years and consumes 3 beers daily. His medical history is significant for hypertension and atherosclerotic heart disease for which he underwent an angioplasty 2 years previously. He is on aspirin, beta blockers and antihypertensive medication. A recent biopsy performed by an oral surgeon revealed epidermoid cancer. A CT scan of the neck confirms the presence of a deeply infiltrating tumor on the lateral border of the tongue. No abnormal lymph nodes are identified. Physical examination revealed a deeply infiltrating 3.0 cm tumor on the lateral border of the tongue (T2N0M0 Stage II carcinoma of the tongue). Preoperatively, once a decision has been made to perform a hemiglossectomy without neck dissection, the surgeon reviews pathology and imaging studies and discusses possible reconstructive options with a reconstructive surgeon. An operative approach is planned. The surgeon discusses the procedure with the patient, and obtains informed consent. At operation, a left hemiglossectomy is performed [The reconstructive surgeon enters and does the reconstruction (separately billable).] Drains are inserted and the wound closed, as appropriate. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

41135 Glossectomy, partial, with unilateral radical neck dissection

Typical Patient: A 57-year-old man presents with a 2 month history of an enlarging, painful “sore” on the left lateral border of the mobile tongue. He has a history of having smoked one pack of cigarettes daily for 40 years and consumes 3 beers daily. His medical history is significant for hypertension and atherosclerotic heart disease for which he underwent an angioplasty two years previously. He is on aspirin, beta blockers and antihypertensive medication. A recent biopsy performed by an oral surgeon revealed epidermoid cancer. A CT scan of the neck confirmed the presence of a tumor on the lateral border of the tongue. A 4 cm left subdiaphragmatic node and several suspicious smaller lymph nodes are identified. Physical exam confirms a 2.5 cm tumor on the lateral border of the tongue and a 4 cm node in the left neck (T2N2aM0 Stage IVa carcinoma of the tongue). The surgeon reviews various treatment options with the patient. Preoperatively, once a decision has been made to perform a partial glossectomy with radical neck dissection, the surgeon reviews pathology and imaging studies. At operation, a left partial glossectomy and radical neck dissection (removing cervical lymph nodes levels I-V with sternomastoid muscle, jugular vein and XIth cranial nerve) is performed and the tongue is sutured in a standard fashion. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

41140 Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection

Typical Patient: A 27-year-old female presents with a childhood diagnosis of a lymphangiomatous lesion of the tongue that has become progressively larger and more ulcerated over the years. Preoperatively, once a decision has been made to operate, the surgeon discusses the procedure with the patient and obtains informed consent. The surgeon reviews pathology and imaging studies and discusses possible reconstructive options with a reconstructive surgeon. At operation, an incision is made in the upper neck with subplatysmal flaps being elevated to allow access to the carotid artery branches. Dissection continues down to the carotid bifurcation and the lingual arteries are ligated bilaterally. Dissection is made around the floor of the mouth and the tongue is separated from the base of tongue and the hyoid. [The reconstructive surgeon enters and does the reconstruction (separately billable).] Drains are inserted and the wound closed, as appropriate. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain her nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

41145 Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection

Typical Patient: A 67-year-old male presents with a large, tumor of the tongue. This has been bothering him for 3 months and he has lost 35 pounds in the last 6 months due to inability to eat. He is a long time smoker and drinks heavily on the weekends. He has a T 4 lesion of the oral tongue with positive nodes on one side of the neck, the largest 4.0 cm in diameter, staged N2B. His chest exam and chest x-ray are negative. A CT scan shows a neoplasm occupying the deep intrinsic muscles of the oral tongue; the tongue base is uninvolved, and there appears to be a space between the neoplasm and the mandible. A biopsy report indicates squamous cell carcinoma with invasion. Preoperatively, once a decision to operate has been made, the surgeon reviews pathology and imaging studies and discusses possible reconstructive options with a reconstructive surgeon. The surgeon discusses the procedure with the patient and obtains informed consent. At operation, a radical neck dissection and a total glossectomy with radical neck dissection is performed. [The reconstructive surgeon enters and does the reconstruction (separately billable).] Drains are inserted and the wound closed, as appropriate. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

41150 Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection

Typical Patient: A 62-year-old man presents with recurrent, multifocal in situ and superficially invasive squamous carcinoma involving the floor of mouth. Patient has previously undergone multiple peroral resections and now has an ill-defined 3.5 cm x 3.0 cm lesion which involves the right floor of mouth and the attached gingiva. Pathology reveals in situ squamous carcinoma with areas of superficial invasion. CT scan shows ill-defined post-operative changes on the right floor of mouth without evidence of mandibular invasion and no evidence of lymph node metastasis. Preoperatively, once a decision to operate has been made, the surgeon reviews pathology and imaging studies and discusses possible reconstructive options with a reconstructive surgeon. The surgeon discusses the procedure with the patient and obtains informed consent. At operation, a transoral right marginal mandibulectomy and resection of the adjacent floor of mouth is performed. [The reconstructive surgeon enters and does the reconstruction (separately billable).] Drains are inserted and the wound closed, as appropriate. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

41153 Glossectomy; composite resection with resection floor of mouth with supra hyoid neck dissection

Typical Patient: A 57-year-old woman presents with multiply recurrent in situ and superficially invasive squamous carcinoma which involves the right ventral surface of the tongue, floor of mouth, and the attached gingiva of the oral cavity. Biopsy reveals in situ and superficially invasive squamous carcinoma. CT scan shows no evidence of mandibular destruction, diffuse post treatment changes involving the right oral tongue and floor of mouth, and no evidence of lymph node metastasis. Preoperatively, once a decision to operate has been made, the surgeon reviews pathology and imaging studies and discusses possible reconstructive options with a reconstructive surgeon. The surgeon discusses the procedure with the patient and obtains informed consent. At operation, the patient undergoes an external, suprahyoid neck dissection, and a marginal mandibulectomy with resection of the floor of mouth and right ventral surface of the tongue. [The reconstructive surgeon enters and does the reconstruction (separately billable).] Drains are inserted and the wound closed, as appropriate. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain her nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

41155 Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)

Typical Patient: A 62-year-old man presents with biopsy-proven invasive squamous carcinoma involving the right oral tongue, right floor of mouth and right mandible, and a large right-sided neck mass. CT scan revealed a lesion in the floor of mouth with right mandibular cortex destruction and a 6 cm matted right cervical mass with necrotic center. Preoperatively, once a decision to operate has been made, the surgeon reviews pathology and imaging studies and discusses possible reconstructive options with a reconstructive surgeon. The surgeon discusses the procedure with the patient and obtains informed consent. At operation, the patient undergoes right radical neck dissection (removing cervical lymph nodes levels I-V with sternomastoid muscle, jugular vein and XIth cranial nerve) and composite resection consisting of the mandible, floor of mouth, and a portion of the oral tongue. [The reconstructive surgeon enters and does the reconstruction (separately billable).] Drains are inserted and the wound closed, as appropriate. Post-operatively, hospital and office visits are conducted as necessary during the 90 day global period to assure that adequate healing has occurred and that the patient is able to maintain his nutrition and that no airway problem has developed. In hospital or through home care, the patient is advanced to a liquid diet and speech and swallowing therapy is ordered.

CMS-1419-FC-042

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December 29, 2004

Mark B. McClellan, MD, PhD

Administrator

Centers for Medicare and Medicaid Services (CMS)

Department of Health and Human Services

Baltimore, MD 21244-8012

Dear Dr. McClellan,

The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) and the American Academy of Neurology (AAN) appreciate the opportunity to respond to the final rule "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2005," as published in the Federal Register on November 15, 2004.

Five-Year Refinement of Relative Value Units

The AANEM and AAN would like to identify the following codes that we believe are misvalued:

Single Fiber Needle Electromyography

We request CPT code 95872: Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle tested be revalued. The current RVU is 1.50.

Single fiber needle electromyography is a very time intensive examination. In single-fiber electromyography, a specially designed needle electrode is used to record and identify action potentials from individual muscle fibers. These recordings are used to calculate the neuromuscular jitter and the muscle fiber density. Jitter recordings can be made in one muscle in 30-45 minutes. The physician must then analyze the results. It is apparent that this code is undervalued when compared to other needle electromyography studies. One extremity needle electromyography, CPT code 95860, appropriately has an RVU of .96 and two extremity needle electromyography, CPT code 95861 has an appropriate RVU of 1.54. Single fiber needle electromyography is often even more challenging and time consuming than routine electromyography and therefore should have a greater RVU than a 2 limb needle electromyography. In addition, SFEMG takes particular expertise and is only performed by electromyographers with additional training in this technique.

Somatosensory Evoked Potentials

CPT code 95925: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral

nerves or skin sites, recording from the central nervous system; in upper limbs be revalued. Analysis of a somatosensory evoked potential requires review of several potentials in the upper extremity study. These include a peripheral response, a subcortical response and a cortical response and these are additionally bilateral studies. They need to be reviewed in regard to the patient's clinical situation and are normalized by age including gestational age. The current RVU is .54.

CPT code 95926: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs be revalued. The current RVU is .54. Analysis of a somatosensory evoked potential requires review of several potentials in this study. These include a peripheral response, a subcortical response and a cortical response and these are additionally bilateral studies. They need to be reviewed in regard to the patient's clinical situation and are normalized by age including gestational age

CPT code 95927: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head be revalued. The current RVU is .54.

Somatosensory evoked potentials are an extension of the electrodiagnostic evaluation and can be used to test conduction in various sensory fibers of the peripheral and central nervous systems. These studies may be used to assess the functional integrity of the central and peripheral sensory pathways. The somatosensory evoked potentials were referenced last year when a new set of codes, central motor evoked potentials, (CPT code 95928, 95929), were being valued. As the physicians were working with the American Medical Association RUC it was apparent to both the RUC and the physicians that the previous physician work values for somatosensory evoked potentials was under valued. When the codes were originally developed, the survey was different and some aspects of physician work were not included in the survey. The work for both somatosensory evoked potentials and central motor evoked potentials are similar. Therefore, the AANEM and the AAN would like to suggest that somatosensory evoked potentials have the same work RVUs (1.50) as central motor evoked potentials. Codes used for SSEP include any and all tested nerves for a particular region, typically a minimum of one nerve on each side, although in many cases may include more. In comparison to nerve conduction studies, SSEP responses are obtained by averaging numerous responses, which takes much more time than a nerve conduction study. Typically, recordings of these averaged responses are repeated to confirm their reliability.

Thank you for the consideration of our request.

Sincerely,

Gloria Galloway, MD
Chair AANEM
Professional Practice Committee

Laura Powers, MD
Chair AAN
Medical Economics and Management Committee

Fifty-Second Annual Scientific Meeting???Monterey, California??? September 21-24, 2005

CMS-1429-FC-44

Submitter: Dr. Randy Wolfe

Date & Time: 12/29/2004

Organization: OMHS Wound Healing Center

Category: Physician

Issue Areas/Comments GENERAL Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

December 14, 2004

Pam West, Physician C Schedule

Contact Center for Medicare and Medicaid Services

Baltimore, MD 21244-1850

Dear Ms. West,

I writing to you regarding the recent decision by CMS to not accept the recommendation of the Resource Utilization Committee, Health Care Professionals Advisory Committee regarding recommended Relative Value Units (RVUs) for CPT code 97605 and CPT code 97606. I would request and urge you to amend the CMS Physician C Schedule to reflect the physician work involved in using vac therapy as recommended by the RCU for the RVUs of 0.55 and 0.60 for negative pressure wound therapy, CPT codes 97605 and 97606 respectively. I have been using Wound Vac for negative pressure wound therapy for about three and a half years. It is a very effective wound therapy treatment, which is cost effective but it is at times somewhat labor intensive. I have been involved in patient care and personally applied the Wound Vac to patients with complex wounds in the perineum that took me and a couple of ICU nurses 45 minutes to an hour to apply the dressing because of the size of the wound and the complexity of the wound making it difficult to get the Wound Vac sponges held in place and ultimately sealed adequately for vac therapy. I have applied the Wound Vac to patients with multiple different problem wounds including sternotomy wounds with exposed mediastinal structures. I have at times went to the operating room to assist surgeons in applying the Wound Vac postoperatively to orthopedic and other wounds. I am sure that you are aware that the Wound Vac is an active therapy treatment for many types of wound which differs from the routine dressings and greatly accelerates healing, stabilizes the tissue and sometimes splints the tissue in painful wounds when there is movement, particularly on chest wounds and abdominal wounds. The Wound Vac maintains a moist wound environment and effectively controls drainage and exudate and helps debride the wound and stimulate new granulation tissue formation.

I appreciate your considering this and if you have any questions, I'd be happy to discuss that with you.

Sincerely,

Randy L. Wolfe, M.D.

CMS-1429-FC-045

December 29, 2004
The Honorable Mark B. McClellan
Administrator
Centers for Medicare and Medicaid Services
U. S. Department of Health and Human Services
Washington, DC 20201

Re: Implementation of the Medicare Initial Preventive Physical Examination (IPPE)

Dear Dr. McClellan:

On behalf of the Alzheimer's Foundation of America (AFA), I am writing to share our views regarding implementation of the new Medicare Initial Preventive Physical Examination (IPPE) by the Centers for Medicare and Medicaid Services (CMS). AFA recognizes that CMS requested additional comments on a limited range of issues in the CY 2005 Physician Fee Schedule Final Rule, and we appreciate the opportunity to share these concerns with you.

AFA and its member organizations provide direct, hands-on services nationwide to individuals with Alzheimer's disease and related dementias, and their families and caregivers. In prior comments on the Proposed Rule, AFA urged CMS to include screening for memory impairment as part of the review of an individual's functional ability and level of safety in the new preventive physical authorized under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

Although memory screenings are not used to diagnose any illness, they can facilitate early detection of Alzheimer's disease and related dementias by identifying the need for subsequent medical evaluation. Early recognition of Alzheimer's disease and related dementias is essential to maximize the therapeutic effects of available and evolving treatments. Such knowledge also empowers individuals to better chart their future course of care and access essential support services, thereby improving their quality of life.

AFA therefore applauds CMS' decision to include screening for cognitive impairment within the scope of the IPPE. As you know, the Final Rule specifically recognizes that "review of the individual's functional ability and level of safety" would include an assessment of the role cognitive impairment may play in affecting an individual's ability to perform activities of daily living.

As a critical next step, AFA urges CMS to conduct a pro-active campaign to educate health care professionals and Medicare beneficiaries about the importance of cognitive impairment screening and its coverage by Medicare as part of the IPPE. Specifically, it is essential for CMS to provide clear guidance to providers and beneficiaries regarding: (1) the circumstances under which screening for cognitive impairment should be conducted; and (2) the extent of Medicare's coverage for services provided in the context of the IPPE or any medically necessary follow-up examination.

This initiative can be seamlessly incorporated into the agency's broader efforts to inform beneficiaries

and providers about establishment of the IPPE and expansion of Medicare preventive benefits pursuant to the MMA. Absent an aggressive education campaign, it is likely that most beneficiaries will not know about the availability of screening for cognitive impairment, and most providers will be unaware of Medicare's coverage of screening services as part of the IPPE.

Failure to effectively communicate this information will have severe consequences for affected Medicare beneficiaries. As AFA's prior comments emphasized, unrecognized dementia can increase the likelihood of avoidable complications such as delirium, adverse drug reactions, and noncompliance with a prescribed medication regimen. These complications reduce the autonomy of affected patients, thereby impeding their ability to perform activities of daily living and compromising their safety.

Such an outcome would be inconsistent with the relevant American Academy of Neurology practice guideline for physicians, which states: "Patients with mild cognitive impairment should be recognized and monitored for cognitive and functional decline due to their increased risk for subsequent dementia."1 Similarly, the U.S. Preventive Health Services Task Force has concluded that while "current evidence does not support routine screening of patients in whom cognitive impairment is not otherwise suspected, clinicians should assess cognitive function whenever cognitive impairment or deterioration is suspected, based on direct observation, patient report, or concerns raised by family members, friends, or caretakers."2 (emphasis added)

Again, we commend CMS for its efforts to improve preventive health services for our nation's Medicare beneficiaries. AFA welcomes the opportunity to work collaboratively with the agency to ensure beneficiaries in need receive screenings for cognitive impairment as part of the IPPE. Please feel free to contact me at 866-232-8484 or Todd Tuten at 202-457-5215 if you have questions or would like more information. Thank you for your consideration.

Sincerely,

Eric J. Hall

CMS-1429-FC-046

February 10, 2005

Mark B. McClellan, MD, PhD, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Washington, DC 20201

RE: CMS-1429-FC, Medicare Program; Revisions in Payment Policies under the Physician Fee Schedule for Calendar Year 2005

Dear Dr. McClellan:

I am submitting this letter on behalf of the 14,000 members of the American Academy of Dermatology Association, to comment on the final rule for implementing the Medicare physician fee schedule for calendar year 2005. The Centers for Medicare and Medicaid Services (CMS) are required to review physician work relative value units at least every five years. The Academy submits the following code (s) for inclusion in that review.

96567 Photodynamic therapy by external application of light to destroy pre-malignant and/or malignant lesions of the skin and adjacent mucosa (e.g. lip) by activation of photosensitive drug(s), each phototherapy exposure session.

Since initial approval of the code by AMA CPT and valuation by the AMA RUC in 2002, input from dermatologists on its normal clinical usage clearly indicates that the degree of direct physician involvement in the performance of this service was significantly underestimated. In fact, experience with the procedure has demonstrated that the original clinical vignette failed entirely to recognize the degree of pain associated with this treatment and the consequent need for direct physician involvement.

The typical patient now undergoes full face treatment of a large number of lesions. This involves both preparation of the skin prior to the treatment to enhance penetration of the medication and the procedure itself that always involves physician pain management. The fact that the procedure would largely be reserved for patients with multiple actinic keratoses and the degree of pain management by the dermatologist that is required per patient during the procedure was not appreciated when the vignette was developed and the code brought before the RUC.

This resulted in a decision by the RUC not to assign any physician work relative value unit for this service. However, given the substantial change in the nature of this service, we are asking for this code to be reexamined under the five year review.

We are not recommending any specific work value for this service at this time. Obviously, there will be a need to conduct a RUC survey to determine the typical amount of physician time and work for this service. We are also not yet prepared to recommend a specific reference code(s) to which to compare the work of the PDT service. However, clearly there are a number of dermatology procedural codes along

with E/M services that might serve as appropriate comparison codes.

We hope the above rationale meets the criteria of compelling evidence for inclusion in the CMS Five Year Review. The Academy, as required by Five Year Review protocol will provide survey data in support of the current clinical usage of this code.

CMS-1429-FC-046 Please contact Norma Border, Senior Manager, Health Policy and Practice (at nborder@aad.org or 847 240 1814) if you have questions about these comments. Thank you.

Sincerely,

James A. Zalla, MD
Chair, Health Care Finance Committee

CC: Brett Coldiron, MD, Vice Chair, Health Care Finance Committee
Daniel M. Siegel, MD, AADA Representative to the AMA/RUC Committee
John D. Barnes, Associate Executive Director, Government Affairs and Health Policy
Judith Magel, Director, Health Policy and Practice
Norma Border, Senior Manager, Health Policy and Practice

CMS-1429-FC-47

Submitter: Dr. Harvey Neiman

Date & Time: 12/30/2004

Organization: ACR

Category: Radiologist

Issue Areas/Comments GENERAL Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

See Attachment

Department of Health and Human Services
Centers for Medicare and Medicaid (CMS)
7500 Security Blvd
Baltimore, Maryland 21244

Below you will find a brief explanation why an attachment can not be provided at this time on a particular document at this time, which was as indicated by the commenter. If you wish to view those attachments that have not been posted, please call CMS at 410-786-9994 or 410-786-7195 Monday through Friday to schedule an appointment.

1. The commenter failed to complete all steps required in order to process their comments. All required fields must be completed in order to attach an attachment.
2. The commenter was referring to another comment received, but did not attach the information they were referring to.
3. The commenter intended to attach more than one attachment. But for some reason, CMS only received one or neither of their attachment.
4. The commenter provided sensitive information, that CMS felt was inappropriate to be posted on the web site.

CMS-1429-FC-48

Submitter: Dr. Alison Loren

Date & Time: 12/30/2004

Organization: University of Pennsylvania

Category: Physician

Issue Areas/Comments GENERAL Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

As a hematologist/oncologist who cares for patients with leukemia, lymphoma, and other blood cancers, I appeal to Dr. Mark McClellan to **STAY THE IMPLEMENTATION OF THE NEW FLOW CYTOMETRY CODES - CPT CODES 88187, 88188, AND 88189 FOR AT LEAST SIX MONTHS.** We need to appoint a committee of professional, university and industry experts to provide additional input and discuss these complex issues with CMS representatives. Failure to adequately support sophisticated studies such as flow cytometry will set us back 20 years in diagnostic services, and many children and the elderly will not have the opportunities for successful treatment we have today. Flow cytometry is **ABSOLUTELY ESSENTIAL** to the diagnosis, monitoring, and treatment of patients with hematologic malignancies. The skill of the technicians and the high level of training and intelligence of the interpreting physicians are of paramount importance. Please do not sell these services short.

CMS-1429-FC-049

Medtronic Neurological
710 Medtronic Pkwy NE
Fridley, MN 55432 USA
www.medtronic.com

December 30, 2004

Centers for Medicare and Medicaid Services
Department of Health & Human Services
Baltimore, MD 21244-801

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

Dear Madam/Sir:

I am writing to call your attention to two apparent errors in the final rule for the 2005 physician fee schedule and to ask that they be corrected as soon as possible through a correction notice in the Federal Register, or in the next quarterly update of the National Physician Fee Schedule Relative Value File. We prefer the former solution which will assure correct RVUs effective January 1, 2005 and obviate the need for physicians to resubmit claims for proper payment for services provided during the first quarter of 2005.

Description of the Errors The errors involve the following two CPT codes:

62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming
62368 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

The first error is that the RVUs assigned to the professional components of the codes in the 2005 proposed rule have now been assigned to the global service codes in the final rule, resulting in inadequate payment for the global services, which involve both technical and professional components. The second error is the elimination of the professional components and technical components and the designation of these services as physicians' services, rather than diagnostic tests.

Background

These codes were new in CPT 1996. They were surveyed and presented to the RUC during the April 1995 RUC meeting. The recommended work RVUs for 62367 and 62368 were 0.48 and 0.75, respectively. CMS accepted these recommendations and published RVUs for the professional component codes only. RVUs for the technical components and global services were not published and

CMS assigned a “carrier-priced” status to them.

For the nine-year period 1996-2004, CMS continued to list line items for the professional component (-26), the technical component (-TC) and the global service. The designation of CPT 62367 and 62368 as diagnostic tests was appropriate and consistent with the PC/TC splits for the comparable pacemaker and ICD analyses in the cardiovascular section of CPT (e.g., CPT codes 93724, 93731, 93732, 93733, 93734, 93735, 93736, 93741, 93742, 93743 and 93744). Unlike those codes, however, the TC components and the global services for 62367 and 62368 were identified as carrier-priced and RVUs were never shown.

In the final rule for 2005, CPT codes 62367 and 62368 were discussed in the section dealing with practice expense issues. Here is the text from the rule:

Comment: The society representing interventional pain physicians questioned the “professional component only” designation we assigned to the codes for the analysis of an implanted intrathecal pump, CPT codes 62367 and 62368, and the subsequent low RVUs for these services. The commenter stated that if the payment is left as proposed, more physicians would stop offering intrathecal pumps to patients.

Response: This was an inadvertent error on our part that we have corrected for the final rule. These services are physicians' services that do not have separate professional and technical components. We thank the commenter for pointing out this error.

Source of the Errors

We do not believe there was the type of error (listing professional components) in the proposed rule that CMS described. Rather, the errors appear to have been made in the final rule. Our theory of the source of the errors relates to the manner in which Addendum B was published in the 2005 proposed rule. For the first time, CMS listed only those codes for which RVUs had been assigned. Because the global service codes and the technical component only codes for CPT 62367 and 62368 have always been carrier-priced, no RVUs have ever been assigned to them. Thus, when CMS published Addendum B and excluded any codes with zero RVUs, the global service codes and the technical component codes were not listed in Addendum B.

We believe that when the pain physicians saw RVUs for only the professional component codes and questioned the payments, CMS looked at Addendum B, saw only a listing for the professional component services and concluded that they had made an error when they listed only the codes with modifier -26. The CMS solution to this problem was to remove the -26 modifier and leave the RVUs in place, thinking that these were the correct RVUs for the global service. As a result, under the final rule, the payment for the global service will now be based incorrectly on the RVUs for the professional component only.

Evidence that Errors Have Been Made

The following tables confirm that these codes have always been recognized as diagnostic tests and that

CMS erroneously assigned the RVUs for the professional component only codes to the global service codes in the 2005 final rule. Note the PE RVUs were charge-based until 1999, when a three-year transition to resource-based PE RVUs began. The PE RVUs became totally resourced based beginning January 1, 2002.

Year	Code	Mod	Work RVU	PE RVU	Malpractice RVU	Total RVUs
1996	62367	26	0.48	0.35	0.07	0.90
1997	62367	26	0.48	0.35	0.07	0.90
1998	62367	26	0.48	0.35	0.07	0.90
1999	62367	26	0.48	0.32	0.05	0.85
2000	62367	26				

0.48
0.26
0.05
0.79
2001
62367
26
0.48
0.20
0.03
0.71
2002
62367
26
0.48
0.14
0.03
0.65
2003
62367
26
0.48
0.13
0.03
0.64
2004
62367
26
0.48
0.13
0.04
0.65
2005 proposed
62367
26
0.48
0.13
0.03
0.64
2005 final
62367
0.48
0.13

0.03
0.64
Year
Code
Mod
Work RVU
PE RVU
Malpractice RVU
Total RVUs
1996
62368
26
0.75
0.55
0.11
1.41
1997
62368
26
0.75
0.55
0.11
1.41
1998
62368
26
0.75
0.55
0.11
1.41
1999
62368
26
0.75
0.49
0.09
1.33
2000
62368
26
0.75
0.40
0.06

1.21
2001
62368
26
0.75
0.30
0.05
1.10
2002
62368
26
0.75
0.20
0.05
1.00
2003
62368
26
0.75
0.19
0.05
0.99
2004
62368
26
0.75
0.19
0.06
1.00
2005 proposed
62368
26
0.75
0.19
0.06
1.00
2005 final rule
62368
0.75
0.19
0.06
1.00

Proposed Solution

We have identified two options for correcting these errors. Our first and preferred option would be to fix the errors through a technical correction notice in the Federal Register. Under this option, CMS would need to re-list the global service and technical component codes as carrier-priced and list the RVUs they have assigned erroneously to the global service to the professional component codes only. This is the most expeditious solution because it is consistent with the treatment of these services over the past nine years, it does not have any effect on any other codes and it would not have any impact on the conversion factor.

The response to the society representing interventional pain physicians could be revised to read as follows: “The listing of RVUs for codes 62367 and 62368 was for the professional components of the services only. Additional payments are made by the carriers for the technical components of these services. Payment for the technical components and the global service will continue to be made at the local level through carrier pricing. We regret any confusion that may have been cause by our decision in the proposed rule to not list codes that are carrier-priced.”

A second option would be for CMS to issue a correction in the first quarterly update of 2005 and permit physicians who performed the global or technical components during the first quarter to resubmit claims in order to receive their correct payments. This option is not preferred because of the added administrative burden on both physicians and carriers.

Finally, we understand that the PEAC submitted its recommended direct practice expense inputs for these codes in March 2003. While the use of carrier-pricing has not been a significant problem, we recognize that the agency might wish to assign RVUs to these codes now that they have been reviewed by the PEAC. We only ask that the issue of changing from carrier-pricing to the assignment of RVUs be done in a proposed rule so that our physician customers and we will have the opportunity to comment on the appropriateness of the change and on the proposed values.

In conclusion, I would like to thank you for your attention to my request. I hope that you will not view these comments as critical. I understand that, in a rule as complex as the physician fee schedule, occasional inadvertent errors are inevitable, especially when the period of time between the close of the comment period for the proposed rule and the publication of the final rule is short.

If you have any questions, please do not hesitate to call me at (763) 505-0201.

Sincerely,

Mark Domyahn
Senior Manager, Health Policy & Payment

CMS-1429-FC-050

December 30, 2004

The Honorable Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Dr. McClellan:

The American Geriatrics Society (AGS) is pleased to submit these comments related to the November 15, 2004 Federal Register publication of the Final Rule with Comment Period for Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005. The AGS is the premier professional organization of health care providers dedicated to improving the health and well-being of all older adults. With an active membership of over 6,000 health care professionals, the AGS has a long history of effecting change in the provision of health care for older adults.

Five-Year Refinement of Work Relative Value Unites for Calendar Year 2004

The AGS endorses the comments being submitted separately by the American Medical Directors Association (AMDA), the American Association of Home Care Physicians (AAHCP) and a coalition of primary care organizations (including AGS) requesting a review of current work values for nursing facility services (CPT 99301-99313) and domiciliary services (CPT 99321-99333) as part of the upcoming five-year review of relative values. Our members commonly provide the services in question and are well aware of the increased work associated with them. We wish to emphasize, too, that we join AMDA and AAHCP in believing that this review should take into account the coding changes recently requested for these services from the CPT Editorial Panel.

In other words, the review of work values for nursing facility services should be based on the following changes to the Nursing Facility Services section of CPT:

- * Revise the structure of the current Comprehensive Nursing Facility Assessment codes to create three levels of service for admissions, consistent with the structure of the three levels of service for admission in the Initial Hospital Care section of CPT;
- * Add a fourth level of service to the Subsequent Nursing Facility Care codes to allow the reporting of a comprehensive level of care (comprehensive history, comprehensive exam, high complexity decision making; and
- * Add a new code in a new subsection (Other Nursing Facility Care) to allow the reporting of a comprehensive annual assessment.

And the review of work values for domiciliary services should be based on the following changes to the Domiciliary Services section of CPT:

* For new patients, the addition of two, more comprehensive levels of service to the existing three levels of service, with modifications to the descriptors for the latter. This would produce a set of codes providing a logical progression in physician work and result in a code structure essentially comparable to the current one for home services (CPT 99341-99345).

* For established patients, the addition of one more comprehensive level of service to the existing three levels of service, with modifications to the descriptors for the existing codes. Once again, this would produce a code structure essentially identical to that now used in reporting home services (CPT 99347-99350).

Rather than repeat the wide range of arguments and evidence cited by AMDA, AAHCP and/or the coalition of primary care organizations, in support of requested work value increases for nursing facility and domiciliary services, AGS would simply like to emphasize a few key points.

With respect to nursing facility services, we believe that the Nursing Home Compendium, 2001, which includes data on more than 3 million residents from approximately 16,600 Medicare- and Medicaid-certified nursing homes in the United States, clearly demonstrates that nursing facility residents are increasingly impaired and that, over time, a larger proportion of these patients requires tube-feeding or suffers from pressure ulcers, further indications of an increasingly complex patient population. Also, as noted by Pillemer and Lachs in "Symposium: The Crisis in Long Term Care: The Crisis in the Long-Term Care Workforce," *Journal of Health Care Law & Policy* 2002, 4:294-307: "...the long-term care population is becoming more disabled and complex to care for. The emphasis throughout the 1990s on transferring elderly people from acute to long-term care settings has had a major impact on nursing homes in particular. This trend toward earlier discharge means that more residents have acute illnesses from which they have not completely recovered at the time they are transferred to long-term care facilities. One of the results of this trend is that nursing homes are now using more complicated technologies that were previously used only in hospitals."

With respect to domiciliary services, AGS agrees with AAHCP that work value increases are required for following three reasons: (1) the work associated with these services has increased over the past decade; (2) these services were never properly evaluated; and (3) the amount of work involved is comparable to that provided to home patients and currently reported by CPT codes 99341-99350. The codes for domiciliary services are intended to apply to patients residing in assisted-living facilities (ALFs), and the number of such facilities and the number of individuals residing in them, have increased quite dramatically. Prospective residents consider entry into an ALF only when disabilities related to chronic illness threaten their independence. Using data from the Medicare Current Beneficiary Survey, Spillman, Liu and McGilliard, in their November 25, 2002 report *Trends in Residential Long-Term Care: Use of Nursing Homes and Assisted Living and Characteristics of Facilities and Residents*, prepared for the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of

Health and Human Services, documented the following changes in ALF residents from 1992 to 1998:

- * The proportion of ALF residents age 85 and older went from 44.8 percent to 50.4 percent.
- * The proportion of ALF residents showing impairment in 3 or more activities of daily living rose from 34.6 percent to 52.1 percent.
- * The proportion of ALF residents reporting their health as excellent or very good declined from 26.0 percent to 11.5 percent.

The authors of this report also saw “...some evidence that assisted living facilities are accepting less healthy residents than in the past or that their residents are ‘aging in place’ and becoming less healthy and more disabled over time.”

AGS also believes it is important to emphasize that initial work values for the domiciliary service codes were developed by staff of the agency then called the Health Care Financing Administration (HCFA)—not from survey data—and these values have not subsequently been subjected to formal review by the AMA’s Relative Value Update Committee (RUC). Further, these HCFA-developed values were based on the faulty assumption that the domiciliary codes required less work than home visits because of the availability of personal assistant services in the former setting. In contrast, we believe that physician work in the domiciliary setting is essentially the same as on a home visit, differing only in that taking the history and caregiver education involves unrelated staff, in addition to family members. In fact, in some facilities, the presence of medical personnel who are unlicensed as nurses can actually increase the need for communication of care plans and clinical changes.

In light of the above information and the additional arguments being made by AMDA, AAHCP and a coalition of primary care organizations, we believe there is more than enough evidence to justify a re-examination of the work values for both nursing facility and domiciliary services. We look forward to working with CMS, the RUC and other physician organizations to assure the proper valuation of these services.

Sincerely,

Meghan Gerety, MD, AGSF
President, The American Geriatrics Society

CMS-1429-FC-051

Timothy P. Singleton, MD
Director, Hematopathology-Flow Cytometry
Fairview-University Hospital, University of Minnesota
Mayo Mail Code 609
420 Delaware Street SE
Minneapolis, MN 55455
2004 December 30

Response to CMS November 2004 ruling to decrease reimbursement for flow cytometry
Re.: CMS-1429-FC

Dear CMS,

I am concerned about the drastic decrease in reimbursement for flow cytometry proposed by CMS in late November 2004 to take effect 1 January 2005. Flow cytometry is standard of care for the diagnosis and treatment of leukemias and lymphomas which disproportionately affect children, the immunocompromised, and the elderly. Flow cytometry provides CD4 counts to guide therapy in HIV-infected patients and CD34 counts for transfusion of stem cells in bone marrow transplants. These are life and death diagnoses and values, literally. The analyses are laborious and time-consuming for the laboratory and for hematopathologists.

In late November 2004 CMS announced that professional reimbursement will be cut as much as 70% and technical reimbursement will be cut around 40%. Academic, independent, and hospital-based laboratories are considering discontinuing flow cytometry in 2005, and those that carry-on will reduce the quality of panels, making it more difficult to provide accurate and timely diagnoses, particularly in complex cases.

I am aware of the process used to establish the new compensation under the 2005 CMS rules. The participants in the study have expressed concern that the process was flawed because of comparison to inappropriate reference codes. As a result, the final assigned values for compensation are not reasonable.

I urge the CMS to begin a dialogue with those affected by the reimbursement cuts to reevaluate the proposed fee schedules that will adversely impact patient care and that may fuel a political backlash by affected vocal patients.

Sincerely,

Timothy P. Singleton, MD
Director, Hematopathology-Flow Cytometry
Fairview-University Hospital, University of Minnesota

CMS-1429-FC-052

Medicare reimbursement policy for clotting factors for 2005.

It appears that Medicare has currently proposed payments for blood clotting factors based the lowest cost products available on the market because the FDA has determined that ALL plasma based and recombinant clotting factors are safe and effective for the treatment of bleeding disorders. While the FDA statement is true it is not accurate to presume individuals with bleeding disorders can simply at will use the cheaper brands of clotting factors without adverse reactions or complications.

The new "Average Sale Price" (ASP) system has been created based upon the average cost to service providers as reported by the manufacturers of clotting factor products. Medicare takes the ASP and adds 6% with an additional .14 cent add-on, Medicare pays 80% of this total. At a glance this formula seems reasonable. However, the ASP currently presented my Medicare is far below what most companies pay the manufacturers to obtain these products. When the 6% and .14 cents is added to the reimbursement amount the actual cost of the clotting factor is barely covered.

Size and type of facility need to be taken into account when setting an average sale price. Providers of home infusion services should have an opportunity to present their actual acquisition prices. The actual acquisition price a provider pays plus 6% and an add-on payment of .14 cents is what should be the standard.

Small businesses, new businesses and medium sized providers are clearly being prejudiced in this pricing model. Large companies which buy these products in huge volume clearly get the best prices, as do PHS facilities like hemophilia treatment centers that get a 15% discount on the purchase price of clotting factors which is subsidized by government programs. This proposed new rule will limit true complete practice, limit consumer choice and reduce necessary services to Medicare beneficiaries. This new rule provides a means by which only a handful of providers (the largest corporations and those with discounted PHS pricing) will be able to deliver safe and effective home infusion services to Medicare recipients and in effect eliminate any competition solely on the basis of acquisition pricing and not the quality of home infusion services provided.

In addition, individuals with financial hardship who can't pay the 20% coinsurance are in the greatest danger of losing their choice of providers and products. These individuals would be forced to use a provider Medicare has favored because of their ability to buy in volume and obtain discounted pricing. There are only two products that smaller companies would be able to dispense and cover their operating costs to Medicare recipients, Red Cross Product (plasma based) and Helixate FS (recombinant). Individuals using other brand named products would be forced to use a small list of providers. This proposed method of reimbursement is discriminatory against smaller home infusion companies providing high quality services to individuals with bleeding disorders. It also discriminates against the poorest individuals by limiting their choice of providers and potentially their access to higher cost clotting factors.

Since Medicare does not pay for the full range of home infusion services that are required to safely and effectively provide factor products for at home infusion therapy, companies will be forced to operate at huge losses if they are able to service Medicare beneficiaries at all. The proposed Medicare payments do not cover the basic cost of the clotting factor, shipping and hazardous waste (sharps) disposal. In addition there is a very long list of service activities that companies are required to provide in addition to the basic infusion product. The added cost of needles, syringes, gauze, alcohol pads, sterile fields, and band-aids far exceeds the proposed reimbursement. The cost associated with professional services which are necessary (i.e. 24/7 on call high-tech clinical infusion personnel, pharmacy personnel, administration, accreditation maintenance, patient education, Social Services, case management and other necessary components of home infusion therapies) will make it almost impossible for companies to accept Medicare clients who use most clotting factors.

The reimbursement rates also favor less service for Medicare beneficiaries by the lack of any home infusion standard which reimbursement is based upon. Companies will provided a list of useless services that fail to meet national standards for home infusion therapies and services. The Federal Register clearly shows a willful lack of information and knowledge on the part of the Medicare system when it comes to clotting factors and individuals affected with bleeding disorders. Medicare has paid for clotting factors but absolutely no service associated with home infusion therapies recognized nationally. Currently, Medicare has proposed reimbursements that will open the door to fully exploit individuals with bleeding disorders by selling them out to the lowest bidder and providers of product with out service or any recognizable standard to ensure the quality of care to individuals using clotting factors. This is the same irresponsible approach which made it possible to allow 80% of all persons with bleeding disorders to be infected with HIV/AIDS. I can not reference any like condition that is life threatening and often debilitating by nature that is addressed only in terms of cost rather than the quality of care and service provided. The Medicare rule encourages substandard care for persons with bleeding disorders and infringes upon the God give human dignity of the same individuals.

I ask that the reimbursement rates proposed be returned to the previous payment method of 95% of AWP or a method which reflects the real acquisition price for each provider of home infusion services in the Medicare system. In addition I ask that ALL home infusion services which include quality assurance programs also be added to the fee schedule as reimbursable services.

CMS-1429-FC-53

Medicare Program;

Submitter: Mr. Bruce Greig

Date & Time: 12/31/2004

Organization: Vanderbilt University Medical Center

Category: Other Health Care Professional

Issue Areas/Comments GENERAL/Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

I am writing to you on behalf of the Immunopathology laboratory of Vanderbilt University Medical Center. We perform the clinical testing services for Flow Cytometry for the hospital, its clinics, and several pathology practices from the middle Tennessee, southern Kentucky, and northern Alabama areas. I strongly request delayed implementation of CMS 1429-FC, specifically in the revised reimbursement tables for Flow Cytometry technical and professional reimbursement. Few patients with leukemia are currently treated and monitored without the diagnostic support provided by flow cytometry. Many patients who once needed open surgical procedures to excise large amounts of tissue can now have diagnoses rendered on small biopsies using non-invasive and far less expensive flow cytometric procedures. The reporting time using this methodology is significantly reduced compared to previous methods. Protocols have been developed around the information gained from these diagnostic services. Children's lives have been saved. The elderly have benefited greatly from these advances in diagnosis and treatment as well. Many children hospitals, small laboratories, general and rural hospitals and cancer centers will NOT be able to provide the same level of services at these levels of reimbursement. The CMS ruling may have a serious impact on often life-threatening diseases and may close or reduce the services of a significant number of laboratories that provide these critical diagnostic tests for leukemia, lymphoma and related diseases. The same level of these medically necessary services will NOT be able to be provided if these marked reductions in the 2005 Medicare fee schedule go into effect. We ask that you allow the medical and laboratory communities to present information for a more appropriate reimbursement structure. More time is needed for public comment as well as wider consideration of the impact of the loss of these services. Several organizations such as the Clinical Cytometry Society, the College of American Pathologists, and the American Medical Association are creating committees and inviting expert opinion on this proposal along with suggestions for appropriate reimbursements. More time is necessary for these groups as well as the medical community at large to have their voices heard. Please give this request serious consideration and delay the implementation of CMS1429-FC.

CMS-1429-FC-54

Submitter: Dr. Philip Zollars

Date & Time: 01/01/2005

Organization: Clin-Path Associates, P.C.

Category : Physician

Issue Areas/Comments

Issues Interim Work Relative Value Units/Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

*CMS-1429-FC I would like to comment on the proposed reimbursement rate for the technical and professional component of flow cytometry. I feel the rates do not reflect the time and expense of operating a flow cytometry laboratory. If these rates are upheld, it is likely that many flow cytometry laboratories may close because they are unable to meet costs. Ultimately, it is the patients that suffer, and in our lab that would include lots of children as well as adults. Our lab runs six days a week and supports twelve hospitals in the Phoenix area. Particularly in pediatric patients, the flow cytometry results are needed to begin immediate treatment, even before an H&E diagnosis is available. I would ask that a quick review be made of the reimbursement schedule and appropriate remedies be made. I think there are other ways to decrease the cost of flow cytometry to CMS without an across the board drastic reduction in fees. I would be glad to share my thoughts on this if you are interested.

Sincerely,

Philip Zollars, M.D.

(pzollars@earthlink.net)

CMS-1429-FC-055

I had applied VAC wound dressings in the operating room under a variety of circumstances. VAC dressings are also effective in any type of operating room debridement, incision and drainage procedure, post skin graft procedure especially in unevenly contoured areas, any type of amputation or partial amputation, especially those that are infected, sternotomy with exposed mediastinal structures, orthopedic trauma, necrotizing fasciitis, burns, and open abdominal and trunk wounds especially abdominal compartment syndromes. Application of VAC dressings can be extremely time consuming, especially in the office. This would apply to areas on the head and neck or in the perineal area, which are unevenly contoured and have medially adjacent areas, which do not necessarily need adherence. The VAC dressing maintains a moist wound healing environment and a closed system to help prevent exposure to infection and decrease the number of dressing changes required in total. It also can provide a splinting effect, especially in the open abdomen or open sternum, allowing earlier ambulation and decreased respiratory complications. It also allows infected wounds to remain open and be serially debrided and allows for secondary closure if a surgery is not initially closed. This also allows for accurately quantifying the amount of exudate and possibly balancing intake and output better and provides protection for flaps and grafts from shearing off prior to complete take. It also protects the peri-wound area from maceration and the dressings stay in place with activity and ambulation, unlike traditional gauze dressings. It also maintains patient dignity by containing the wound, exudate, or odor that can be embarrassing and performs some level of debridement with each dressing change.

CPT Code precedence for "burns and local treatment" has RVUs as follows:

- 16010; dressings and/or debridement, initial or subsequent; under anesthesia, small; work RVU equals 0.87.
- 16015; under anesthesia, medium or large, or with major debridement; work RVU equals 2.35.
- 16020; without anesthesia, office or hospital, small; work RVU equals 0.80.
- 16025; without anesthesia, medium; work RVU equals 1.85.

Please amend the CMS physician fee schedule to reflect the physician work involved in using VAC therapy and accept the recommendations from the RUC Committee of RYUs 0.55 and 0.60 for NPWT, CPT Codes 97605 and 97606 respectively.

With best regards,

Thomas C. McFadden, Jr., M.D., FACS

TCM/jwb/mds

Steven Phillips, Director of Practioner Services
Center for Medicaid and Medicare Services

CMS-1429-FC-56

Submitter: Dr. Daniel Dubovsky

Date & Time: 01/02/2005

Organization: Atlanta Cancer Care

Category: Other Health Care Provider

Issue Areas/Comments GENERAL/Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

See Attachment

Department of Health and Human Services
Centers for Medicare and Medicaid (CMS)
7500 Security Blvd
Baltimore, Maryland 21244

Below you will find a brief explanation why an attachment can not be provided at this time on a particular document at this time, which was as indicated by the commenter. If you wish to view those attachments that have not been posted, please call CMS at 410-786-9994 or 410-786-7195 Monday through Friday to schedule an appointment.

1. The commenter failed to complete all steps required in order to process their comments. All required fields must be completed in order to attach an attachment.
2. The commenter was referring to another comment received, but did not attach the information they were referring to.
3. The commenter intended to attach more than one attachment. But for some reason, CMS only received one or neither of their attachment.
4. The commenter provided sensitive information, that CMS felt was inappropriate to be posted on the web site.

CMS-1429-FC-57

Submitter: Dr. H. Jean Khoury

Date & Time: 01/02/2005

Organization: Emory University/Winship Cancer Institute

Category: Physician

Issue Areas/Comments GENERAL/Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

January 2, 2005 Center for Medicare and Medicaid Services Dept. of Health and Human Services
ATTN: CMS-1429-FC PO Box 8012 Baltimore, MD 21244-8012 Subject: November 2004 Medicare ruling for flow Cytometry CPT codes - CMS-1429-FC To Whom It May Concern: I am writing this email to you to express my grave concern over the severe decreases in reimbursement for flow cytometry services proposed by CMS. As a hematologist treating patients with Leukemias, and especially with the inherent difficulties to accurately diagnose leukemia by morphology, it is vital for patients and to practice state-of-the art Medicine to have access to the services of an excellent flow cytometrist hematopathologist in order to adequately diagnose and treat these patients. Many of the major advances in the success of treating patients with leukemia and lymphoma over the last twenty years have been predicated on this diagnostic modality. If a cut in reimbursement were to result in decreased availability of flow cytometry services, our patients will undoubtedly be severely adversely impacted. This should not be allowed to happen, as flow cytometry is a crucial diagnostic/prognostic pathology service. I urge CMS to withhold these drastic cuts in reimbursement and allow the medical community to present information for a more appropriate billing and reimbursement structure.

Sincerely,

H. Jean Khoury, MD, FACP
Section Chief, Hematology
Associate Professor of Hematology/Oncology
Emory University School of Medicine
1365 Clifton Road NE, Suite 3007
Atlanta, GA 30322
Tel: (404) 778-3932
Fax: (404) 778-5520
e-mail: hkhoury@emory.edu

CMS-1429-FC-58

Submitter: Ms. Elizabeth Stone

Date & Time: 01/03/2005

Organization: Clinical Cytometry Society

Category: Individual

Issue Areas/Comments GENERAL/Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

CMS has misjudged the current utilization patterns, the cost to provide and the value that flow cytometry adds to patient care. American citizens may be denied access to or left with less than thorough testing for leukemia and lymphoma due to the drastic and inappropriate cuts to reimbursement. CMS-1429-FC I am involved in this science as a practitioner (Eosterix national reference lab for oncology diagnostics, a leader in the clinical flow cytometry industry) and as regulatory committee chair for Clinical Cytometry Society. I am an advocate for the patient, I have no vested interest in reimbursement figures. What the medical community, and subsequently CMS, needs is a thorough review of issues related to applications of clinical flow cytometry. In 1997 a very thorough consensus conference was held to establish guidelines for this valuable tool in diagnostic/prognostic and patient monitoring. There is a tremendous need to recreate this process, gathering experts representing all aspects of the application. This is overdue. CMS is acting on incomplete data and therefore the 2005 ruling is inappropriate. The following items should be addressed in the review of this issue: 1. Signs and Symptoms justifying this testing (current utilization practice) 2. The relationship of flow with immunohistochemistry testing on a single sample (both diagnostic and follow up cases) 3. The actual cost of testing (multiple redundant markers are analyzed and not billed due to the nature of the test) 4. How this test relates to oncology patient management/monitoring over time 5. The variety of CMS local carrier rulings, a consensus for a correct approach should define the practice so thoroughly that individual carriers would all be consistent, for instance, the number of makers reimbursed per case. I think CMS should institute a thorough review to get clinical flow cytometry ruling right and appropriate. All providers will readily participate. The process of implementing this review during 2005 should be made public and participation encouraged by all involved. If no action is taken, the result could be less access to the testing locally (laboratories shutting down) and less thorough testing to save cost and maintain laboratory viability. Thank you for accepting these concerns and for responding with your intended actions. Both the technical and professional components should be reviewed.

Sincerely,

Elizabeth Stone, BS, MT (ASCP)

a concerned citizen and patient advocate

CMS-1429-FC-059

Mark McClellan, MD
Administration
Centers for Medicare and Medicaid Services
200 Independence Ave. SW
Washington, DC 20201

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for 2005
January 3, 2005

Dear Dr. McClellan:

On behalf of the more than 150,000 members and associates engaged in the practice, research and teaching of psychology I want to thank the Centers for Medicare and Medicaid Services (CMS) for amending the supervision requirements for psychological diagnostic testing. Allowing clinical psychologists to supervise psychological diagnostic testing will improve patients' access to timely health care.

Reviewing the final rule, we had two concerns regarding practice expense information that CMS applied to two CPT codes and are pleased with the outcomes that we reached with CMS staff. In the proposed rule, CMS requested equipment expense information for CPT codes 90875 (biofeedback) and 96117 (neurobehavioral status exam). We submitted pricing information from the manufacturers as well as lists of needed equipment from a panel of psychologists. In the final rule, CMS indicates that it has accepted our data; however, the total equipment costs cited in the final rule do not reflect the information that we provided.

Since the final rule was published we have spoken with CMS staff handling the practice expense inputs and are satisfied with the outcomes. We agree with CMS that reducing the inputs for 90875 (biofeedback) from the \$11,310.00 that we submitted to the \$9,925.00 accepted by CMS is reasonable. For 96117 (neurobehavioral status exam) we had submitted \$13,635.00 worth of equipment expenses. CMS misinterpreted the use of our equipment and reduced the equipment costs to equal one-twelfth of our submission, or \$1,136.25. In discussions with CMS staff, we clarified that all twelve of the tests listed in our equipment costs are conducted on the typical patient and therefore the entire \$13,635.00 should be recognized. CMS staff have agreed with us and will be posting the correction in the March 2005 Correction Notice. We appreciate CMS staff's availability to work with us to rectify the problem and look forward to the Correction Notice.

Thank you for your on-going support of psychological health services for Medicare beneficiaries. Should have any questions, please contact me at (202) 336-5889, or via email at DPedulla@APA.org.

Sincerely,
Diane M. Pedulla, JD
Director, Regulatory Affairs

CMS-1429-FC-060

December 31, 2004

Mark B. McClellan, M.D.
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8012
Baltimore, Maryland 21244-8012

Dear Dr. McClellan:

On behalf of HealthTrac, Inc. and its affiliated companies, I am offering the following comments on the Medicare Physician Fee Schedule Calendar Year 2005 Final Rule. HealthTrac is certified as a both a portable x-ray supplier and independent diagnostic testing facility providing non-invasive diagnostic testing to the infirmed elderly, operating in Connecticut, Massachusetts, New Jersey, New York,

Pennsylvania and Rhode Island. HealthTrac and other members of the National Association for the Support of Long Term Care (NASL) commented on the provisions of the Medicare Physician Fee Schedule Calendar Year 2005 Proposed Rule. We requested the removal of the portable x-ray “specialty” from the non-physician work pool methodology, using the practice expense survey data submitted by the American College of Radiology (ACR) for the calendar year 2005. The final rule contained the CMS comments denying our request in section II.D.5 “Q-Code for Set-Up of Portable X-Ray Equipment.” We offer the following comments in response to the Final Rule.

Section II.D.5 Q-Code for Set-Up of Portable X-Ray Equipment

First, we disagree with the comments proffered by the National Association of Portable X-Ray Providers (NAPXP). We were afforded timely analysis and explanation of the impact of removing the portable x-ray specialty from the non-physician work pool by CMS staff, following our request for further explanation.

Second, the comment stated that our request for removal from the non-physician work pool could not be accommodated as “payments for other services in the non-physician work pool would also decline affecting other specialties, such as radiology, radiation oncology, cardiology, allergy, audiology and others.” The comment went further to state that, “the set-up code is yet to be refined.” The rationale given for denying our request is inconsistent with the rationale used in evaluating and granting other specialty services request for removal from the non-physician work pool. CMS has never considered the effect on the remainder of the non-physician work pool when a specialty sought removal of its codes from the methodology, nor has failure to refine any one code for a specific specialty ever precluded the granting of such a request. Despite the fact that portable x-ray and its set-up code have been under-reimbursed for years and granting such relief would have increased payments to the portable x-ray

specialty by less than \$10 million per year, our request was flatly denied. Other specialties that were removed from the non-physician work pool received increased reimbursement without regard to the effect on other specialties. In 1995-6, when CMS decided to bundle the EKG transportation costs within the EKG procedure code, there was no consideration given to the portable x-ray specialty when it lost several millions of dollars reimbursement that were then allocated to other specialties performing EKG's. In neither case was the portable x-ray specialty treated fairly or equitably. We expect consistency and fairness in CMS policy making.

Third, the comment stated, "we believe it is preferable to address refinement of the code and pricing of the code outside the non-physician work pool together." As no timeframe was stated in the comment, I am requesting consideration to have the refinement of the code and revised pricing of the code take place in 2005, prior to the development of the proposed rule for the 2006 physician fee schedule. I am also requesting that NASL, representing the larger suppliers of portable x-ray services participate in that process to ensure accurate information on the time required to perform the set-up function is provided to CMS or its agents used in this process.

We appreciate the efforts made by CMS staff in providing the information needed by the portable x-ray suppliers in commenting on policy decisions effecting the Medicare payments for our services.

Sincerely,

Daniel T. McDonnell
Executive Vice President
716-614-3260 ext. 120
McdonnellD@healthTrac-inc.com