

or more of the reference services. In compiling the set, we attempted to include—(1) services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following the discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome this presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In addition, we used statistical tests to determine

whether there was enough agreement among the groups of the panel and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the December 2002 final rule. We did not modify the RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the 1993 physician fee schedule. The statistical tests were described in detail in the November 25, 1992 final rule (57 FR 55938).

Our decision to convene multispecialty panels of physicians and to apply the statistical tests described above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties.

We also received comments on RVUs that were interim for 2003, but for

which we did not submit the RVUs to the panel for review for a variety of reasons. These comments and our decisions on those RVUs commented upon are discussed in further detail below.

The table below lists those interim codes reviewed under the refinement panel process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- 2003 Work RVU. The work RVUs that appeared in the December 2002 rule are shown for each reviewed code.
- Requested Work RVU. This column identifies the work RVUs requested by commenters.
- 2004 Work RVU. This column contains the final RVUs for physician work. (These work RVUs may differ from the work RVUs in Addenda B that reflect the adjustment to work RVUs to match the MEI weights.)

TABLE 4.—CODES REVIEWED UNDER THE REFINEMENT PANEL PROCESS

CPT code ¹	Mod	Descriptor	2003 work RVU	Requested work RVU	2004 work RVU
17310	Mohs any stage > 5spec each	0.62	0.95	0.95
43219*	Esophagus endoscopy	2.80	2.80
43256*	Uppr gi endoscopy w stent	4.35	4.35
44383*	Ileoscopy w/stent	2.94	2.94
45340	Sig w/balloon dilation	1.66	1.96	1.89
51798	Us urine capacity measure	0.00	0.38	0.00
75954	Iliac aneurysm endovas rpr	1.36	2.93	2.25
92613	Endoscopy swallow tst (fees)	0.00	0.99	0.71
92615	Eval laryngoscopy sense test	0.00	0.88	0.63
92617	Interprt fees/laryngeal test	0.00	1.10	0.79

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* The work RVUs for these codes were revised for 2003 by CMS to finalize outstanding issues related to the five-year review of the gastroenterology codes.

2. Interim 2003 Codes

CPT code 17310 *Chemosurgery (Mohs micrographic technique) including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathological preparation including the first routine stain (e.g. hematoxylin and eosin, toluidine blue); each additional specimen after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure).*

Prior to 2003, this code was reported once for all specimens over five generated during a particular stage of

Mohs surgery. Beginning in 2003, the code is used to report each specimen over five during a particular stage of Mohs surgery. The RUC recommended maintaining 0.95 work RVUs for this code as an interim value. We disagreed and assigned a work value of 0.62 work RVUs to this code pending further recommendations from the RUC. We believed this value was appropriate for the new descriptor since it allows reporting of CPT code 17310 for each specimen rather than reporting once for all specimens. It also places this code in the correct rank with the other Mohs surgery services, CPT codes 17304–17307, and with the codes for pathology

consultation during surgery, CPT codes 88331 and 88332.

Commenters disagreed with the rationale we had used to arrive at the interim work value and indicated that we used inappropriate time/intensity data and failed to include surgery work, focusing only on pathology work. Commenters also stated that the intent of this code has not changed and that CMS had ignored past policy which recognizes CPT code 17310 as an add-on service and thus allows the separate billing of services for each additional specimen beyond the first five. Based on these comments, we referred this code to the multispecialty validation panel for review.