

We accepted the RUC recommendations for work RVUs for these services.

*Comment:* Some commenters stated that new values have been established for these services based on new survey data and that the RUC has new recommendations for these services. In their comments on the December 31, 2002 rule, the RUC included these new work RVU recommendations and urged us to review these during the refinement process.

*Response:* We are in agreement with the RUC recommended values for these services. However, to provide an opportunity for public comment we are including these in the RUC Recommendations for New and Revised codes for 2004 (table xx) and will consider the RVUs interim for 2004.

CPT code 75954 *Endovascular graft placement for repair of iliac artery (e.g. aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) radiological supervision and interpretation.*

The RUC agreed with the specialty societies and recommended a value of 2.93 work RVUs based on comparing this code to CPT codes 75952, *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation*, (work RVU of 4.5) and 75953, *Placement of proximal or distal extension prosthesis for endovascular repair of infra renal abdominal aortic aneurysm, radiological supervision and interpretation*, (work RVU of 1.36). The recommended RVU was midway between the RVUs of the reference procedures. We did not agree with the RUC recommendation. Based on the specialty societies' description of the work of CPT code 75954 (which is virtually identical to the description of the work for CPT code 75953) and in order to maintain correct rank order in this family of codes, we assigned a work RVU of 1.36 to CPT code 75954.

*Comment:* Some commenters expressed concern about the rejection of the RUC recommendation, particularly since the recommendation was based on data presented by several specialty societies. The commenters stated that the data reflected the proper rank order of this service and indicated that physicians in those specialties that perform ileac aneurysm endorepair may be in a better position to judge the relationship of this code to other imaging services. Based on these comments, we referred this code to the multispecialty validation panel for review.

*Response:* As a result of the statistical analysis of the 2003 multispecialty

validation panel ratings, we have assigned 2.25 work RVUs to CPT code 75954.

CPT code 92610 *Clinical Evaluation of swallowing function.*

In the December 2002 final rule, this CPT code replaced HCPCS code G0195, which had a work RVU of 1.50 in 2002. The Healthcare Professionals Advisory Committee (HCPAC) recommendation of a work RVU of 0.00 for CPT code 92610 was accepted by CMS.

*Comment:* Some commenters representing the long term care industry expressed concern with the reduction in work for this service. The rule provided no explanation of the HCPAC recommendation of 0.00 work RVUs for this service and the commenters requested that this issue be addressed.

*Response:* As requested by the commenters, a discussion of the HCPAC recommendation of 0.00 work RVUs was provided as part of the multispecialty validation panel, which was attended by the commenters.

CPT codes 92613 *Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; physician interpretation and report only*, 92615 *Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; physician interpretation and report only*, and 92617 *Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; physician interpretation and report only.*

We did not accept the RUC recommendations for work RVUs for these services (0.99 for 92613, 0.88 for 92615 and 1.10 for 92617) and assigned each of these CPT codes a work RVU of 0.00. We stated that these three services refer only to a separately identified physician review and interpretation of the fiberoptic endoscopic evaluation and that we consider this physician interpretation and report bundled into an E/M service. We stated that the physician who does not perform the testing should only bill for the patient when performing an E/M service, not as the supervisor of another professional performing and reviewing the initial fiberoptic endoscopic evaluation. The interpretation is an integral part of the testing itself and, if a nonphysician professional has the credentials and experience to perform this testing, then that professional should also provide the interpretation of the findings.

*Comment:* Some commenters urged us to reconsider the RVUs and payment policies related to these services and to accept the RUC recommendations for

these codes. The commenters asserted that the physician's detailed frame-by-frame analysis of the video recorded procedure needed to develop the diagnosis and report following this testing is not related to an E/M service. Rather, this is similar to other services where there is a report and interpretation by the physician that is separate from an E/M service. The commenters further stated that the RUC valued each procedure code and physician interpretation and report code separately, based on the coding structure created by CPT. As a result, the interpretation and reporting is separated from each test, and the RUC recommendations do not combine the interpretation with the testing. If the code were to combine the work of interpretation and the testing then the code descriptor would need to be modified and work RVUs revalued. As a final point, commenters disputed our assertion that a nonphysician professional with the credentials and experience to perform this testing should also provide the interpretation of the findings. Based on these comments we referred this code to the multispecialty validation panel for review.

*Response:* As a result of the statistical analysis of the 2003 multispecialty validation panel ratings, we have assigned 0.71 work RVUs to CPT code 92613; 0.63 work RVUs to CPT code 92615; 0.79 work RVUs to CPT code 92617.

In the December 31, 2002 final rule (67 FR 79966), we also responded to the RUC recommendations on the practice expense inputs for the new and revised CPT codes for CY 2003. There were no comments received on these and therefore we are finalizing our proposals.

#### *Late RUC Recommendations*

As we indicated in the August 15, 2003 proposed rule, RUC recommendations for RVUs for 23 new CPT codes for 2003 were received too late for incorporation in the December 31, 2002 final rule. We proposed interim RVUs for these codes and, as with all interim values, these were subject to comment. In their comments on the December 2002 final rule, the AMA-RUC requested that we consider their late recommendations for these codes during refinement. Several specialties also requested that we consider the late RUC recommendations. We had considered addressing these as part of the refinement process, but determined that we should follow the process used for all RUC recommendations and solicit public comment on the valuation