

**AMA/Specialty Society RVS Update Committee
Renaissance Hotel – Chicago, Illinois
April 27-May 1, 2016**

Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Thursday, April 28, 2016 at 3:00pm. The following RUC Members were in attendance:

Peter K. Smith, MD
Margie Andraea, MD
Michael D. Bishop, MD
James Blankenship, MD
Robert Dale Blasier, MD
Albert Bothe, MD
Ronald Burd, MD
Scott Collins, MD
Thomas Cooper, MD
Gregory DeMeo, MD
Jane Dillon, MD
Verdi DiSesa, MD
James Gajewski, MD
David F. Hitzeman, DO
Walter Larimore, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD
Scott Manaker, MD
Geraldine McGinty, MD
Margaret Neal, MD
Guy Orangio, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Joseph R. Schlecht, DO
Stanley Stead, MD
James Waldorf, MD
Jane V. White, PhD, RD, FADA
Jennifer L. Wiler, MD
George Williams, MD

Amr Abouleish, MD, MBA*
Allan Anderson, MD*
Gregory L. Barkley, MD*
Eileen Brewer, MD*
Jimmy Clark, MD*
Joseph Cleveland Jr., MD *
William D. Donovan, MD *
Jeffrey Edelstein, MD*
William Fox, MD*
Michael J. Gerardi, MD*
David Han, MD*
Peter Hollmann, MD*
John Lanza, MD*
Mollie MacCormack, MD, FAAD*
Paul Martin, DO, FACOFP *
Daniel Nagle, MD*
Dee Adams Nikjeh, PhD, CCP-SLP*
Scott Oates, MD*
Sandra Reed, MD*
Christopher Senkowski, MD, FACS*
M. Eugene Sherman, MD*
Samuel Silver, MD, PhD*
Norman Smith, MD*
Holly L. Stanley, MD*
Robert J. Stomel, DO*
G. Edward Vates, MD*
Thomas Weida, MD*
Adam Weinstein, MD*

*Alternate

II. Chair's Report

- Doctor Smith welcomed everyone to the RUC Meeting.
- Doctor Smith welcomed the Centers for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting, and asked that Doctor Hambrick introduce the staff during her update.

- Doctor Smith welcomed the following Contractor Medical Directors:
 - Charles Haley, MD, MS, FACP

- Doctor Smith welcomed the following Members of the CPT Editorial Panel:
 - Albert Bothe, MD – Departing as CPT RUC Member
 - Kathy Krol, MD – Panel Member Observer, Incoming CPT RUC Member
 - Kenneth Brin, MD – CPT Panel Chair

- Doctor Smith recognized departing RUC members:
 - Thomas Cooper, MD
 - Robert Kossmann, MD
 - Geraldine McGinty, MD
 - Joseph Schlecht, MD

- Doctor Smith welcomed the following Researcher:
 - David Chan, MD, PhD
 - Assistant Professor of Medicine, Stanford School of Medicine

- Doctor Smith welcomed the following Researcher:
 - Armando Lara-Millan, PhD
 - RWJF Scholars in Health Policy Research Program University of California, Berkeley/UCSF
 - Proposed a scientific publication related to his observations of the RUC process.
 - All observations de-identified, publication to be reviewed by AMA
 - Publication to be delayed by 1 year, so that code values will be finalized
 - Individual interviews will be accompanied by individual consent, and will be voluntary

- Doctor Smith discussed a meeting with Sean Cavanaugh from CMS on March 23, 2016
 - Progress and Next Steps – Non Face-to-Face Services/Care Collaboration
 - Physical Medicine and Rehabilitation Update/Discussion
 - RUC Recommendations on Data Collection for Services in Surgical Global Periods
 - Importance of Intensity in Valuation

- Doctor Smith reviewed the agenda items under Other Business:
 - Time and Intensity
 - The RUC will continue to elaborate the importance of time and intensity in the RUC recommendations letter with our next submission to CMS
 - ACOG Letter to CMS included in the agenda materials (Tab 54) concerning time and intensity when valuing services
 - ACS Letter to the RUC to discuss scrub, dress and wait intensity (RUC will discuss under other business)

- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
 - Codes with ≥ 1 million Medicare Claims = **75 respondents**
 - Codes with Medicare Claims from 100,000 to 999,999 = **50 respondents**
 - Codes with $< 100,000$ Medicare = **30 respondents**

- Surveys below the established thresholds for services with Medicare claims of 100,000 or greater will be reviewed as interim and specialty societies will need to resurvey for the next meeting.
- Doctor Smith laid out the following guidelines related to confidentiality:
 - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk)
 - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
- Doctor Smith shared the following procedural rules for RUC members:
 - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes
 - RUC members or alternates sitting at the table may not present or debate for their society
 - Expert Panel – RUC Members exercise their independent judgment and are not advocates for their specialty
- Doctor Smith laid out the following procedural guidelines related to specialty society staff/consultants:
 - Specialty Society Staff or Consultants should not present/speak to issues at the RUC Subcommittee, Workgroup or Facilitation meetings – other than providing a point of clarification
- Doctor Smith laid out the following procedural guidelines related to commenting specialty societies:
 - In October 2013, the RUC determined which members may be “conflicted” to speak to an issue before the RUC:
 - 1) a specialty surveyed (LOI=1) or
 - 2) a specialty submitted written comments (LOI=2).RUC members from these specialties are not assigned to review those tabs.
 - The RUC also recommended that the RUC Chair welcome the RUC Advisor for any specialty society that submitted written comments (LOI=2), to come to the table to verbally address their written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.
- Doctor Smith shared the following guidelines related to voting:
 - RUC votes are published annually on the AMA RBRVS website each November for the previous CPT cycle.
 - The RUC votes on every work RVU, including facilitation reports
To insure we have 28 votes, please share voting remotes with your alternate if you step away from the table
 - If members are going to abstain from voting or leave the table, please notify AMA staff so we may account for all 28 votes
- Doctor Smith announced:
 - That all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.

- Only use Wi-Fi when necessary and limit to one device so they do not interrupt the work of the RUC.

III. Director's Report

Sherry L. Smith, MS, CPA, Director of Physician Payment Policy and Systems, AMA provided the following Director's Report:

- The RUC Database has been updated to include 2015 Medicare Claims data. Please ensure you have downloaded the most recent version.

IV. CPT Editorial Panel Update

Doctor Albert Bothe provided the following update of the CPT Editorial Panel:

- The CPT Editorial Panel last met in Miami in February and reviewed 29 tabs.
- The telehealth workgroup approved a new modifier which can be attached to certain CPT codes to indicate synchronous telehealth care. Likewise a new appendix will be included in the CPT book to list the approved codes which the modifier can be used with.
- The CPT also considered the status of Category II codes and opted to maintain these codes for the time being.
- Doctor Rubin was the RUC representative to the CPT and the CPT continues to welcome any RUC members who wish to attend.
- Doctor Kathy Krol will be taking over as the CPT liaison to the RUC moving forward as Doctor Bothe has completed his 8 year term limit.

V. Approval of Minutes from January 2016 RUC Meeting

- The RUC approved the January 2016 RUC Meeting Minutes as submitted.

VI. Centers for Medicare and Medicaid Services Update (Informational)

Doctor Edith Hambrick provided the report of the Centers for Medicare & Medicaid Services (CMS):

- Doctor Hambrick introduced staff from CMS attending this meeting:
 - Edith Hambrick, MD - CMS Medical Officer
 - Donta Henson – Analyst, Division of Practitioner Services
 - Ryan Howe – Director, Division of Practitioner Services
 - Steve Phurrough, MD - CMS Medical Officer
- Doctor Hambrick announced that the Agency is working on the notice of proposed rulemaking (NPRM). Comments have been provided and any additional ones should be given to CMS as soon as possible.

VII. Contractor Medical Director Update (Informational)

Doctor Charles E. Haley, MD, MS, FACP, Medicare Contractor Medical Director, Noridian, provided the contractor medical director update:

- Medicare consists of many drug benefits and problems often occur at the intersection of these benefits. Discussions have occurred regarding prolonged drug infusions that start at in a physician's office, complete outside of a physician's office, and then the equipment is subsequently returned to the physician's office. There is currently ambiguity regarding where to categorize this since the patient is not under continuous physician observation. CMS has released information for the CMDs on how to pay for these infusions and review of this guidance is underway.

VIII. Washington Update (Informational)

Sandy Marks, AMA staff, provided an update on MACRA:

- The proposed rule for MACRA was posted and is currently under review by the AMA team.
- A presentation was given to explain the changes that MACRA introduces:
 - MACRA permanently eliminated SGR, establishes a path for alternative payment models (APMs), and consolidates reporting programs (MIPS).
 - MIPS is comprised of four components: 1) Quality Measurement; 2) Resource Use; 3) EHR Meaningful Use; and 4) Clinical Practice Improvement Activities.
 - Discussions at this meeting will further elaborate on requirements and options for participation via APMs. An AMA resource, "A Guide To Physician-Focused Alternative Payment Models", is available online at: <http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-alternative-payment-models.page>.
 - Recent MACRA Requests for Information include: 1) Quality Measure Development Plan; 2) Episode Groups; 3) Patient Condition Groups; and 4) Patient Relationship Codes.
- Additional resources about MACRA are available online: www.ama-assn.org/go/medicarepayment.

IX. Medicare Spending and Utilization Growth for 2015 (Informational)

Dr. Kurt Gillis, AMA staff, provided an update on Medicare Physician Payment Schedule - Spending and Utilization Growth for 2015:

- A presentation was given to review the analysis of Medicare Physician/Supplier Procedure Summary files (PSPS):
 - Estimates are based on claims processed through December 31, 2015 (>92% complete).

- General trends show that spending increased 0.8% due to: a decrease in pay (-0.4%); increase in fee-for-service enrollment (0.2%); and increase in utilization per enrollee (1.0%). Overall, 2015 was another year of low spending and utilization growth
- Imaging, Evaluation & Management, Procedure, and Test -specific spending trends were discussed.

Dr. Gillis presentation is attached to these minutes.

X. Relative Value Recommendations for CPT 2018:

Psychiatric Collaborative Care Management Services (Tab 4)

Jeremy S. Musher, MD (APA); Sherry Barron-Seabrook, MD (AACAP); Jennifer Aloff, MD (AAFP); Mary Newman, MD (ACP); John Agens, MD (AGS)

In February 2016, the CPT Editorial Panel created three new codes to describe a model for providing psychiatric care in the primary care setting. This code set is one of several in response to a request from CMS to facilitate appropriate valuation of the services furnished under the Collaborative Care Model (CoCM). This CoCM is used to treat patients with common psychiatric conditions in the primary care setting through the provision of a defined set of services which operationalize the following core concepts: 1) Patient-Centered Team Care/Collaborative Care; 2) Population-Based Care; 3) Measurement-Based Treatment to Target; and 4) Evidence-Based Care.

The RUC reviewed the new code set for Psychiatric Collaborative Care Management, which captures a primary care physician working with a behavioral health manager and consulting psychiatrist to manage patient psychiatric care. The specialty societies requested that this issue be deferred until the October 2016 RUC meeting. The RUC noted that an Ad Hoc Workgroup has been created to provide feedback and guidance to the specialties involved to appropriately survey this code set. The Workgroup will review the unique survey plan before it goes to the Research Subcommittee for approval. **The RUC recommends deferral of the valuation of CPT codes 99492, 99493, and 99494 to the October 2016 RUC meeting.**

Cognitive Impairment Assessment and Care Plan Services (Tab 5)

Jennifer Aloff, MD (AAFP); Kevin Keber, MD (AAN); Donna Sweet, MD (ACP); John Agens, MD (AGS); Robert Zorowitz, MD (ACP); Jeremy Musher, MD (APA)

In February 2016, the CPT Editorial Panel added a new code to describe an evidenced based cognitive service. This was one of several in response to a CMS request to capture cognitive service codes not currently described by Evaluation and Management (E/M) services. This service is provided when a comprehensive evaluation of a new or existing patient exhibiting signs of cognitive impairment is required to establish a diagnosis etiology and severity for the condition. The service includes a thorough evaluation of medical and psychosocial factors potentially contributing to increased morbidity. Typically, these patients are referred by a primary caregiver. There are ten required elements for the service, and all ten must be performed in order for the code to be reported. This service includes two distinct activities, assessment of the patient and establishment of care plan that is shared with the patient and caregiver, along with education. It is important that all elements are performed to be able to report this code. Other face-to-face E/M codes cannot be reported on the same date as this service to prevent any overlap with E/M codes.

99483 Assessment of and care planning for the patient with cognitive impairment

The RUC reviewed the survey results from 165 practicing physicians. 91% of respondents found the vignette to be typical, and a median performance rate of 20 demonstrated the respondents were very familiar with the service. These respondents agreed with the following physician time components: pre-service time of 15 minutes, intra-service time of 50 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work value of 3.44 is appropriate for the physician work required to perform this service. The RUC compared the surveyed code to a key reference code 99327 *Domiciliary or rest home visit for the evaluation and management of a new patient* (work RVU= 3.46, pre-service time=15 minutes, intra time= 50 minutes, and immediate post time=25 minutes) and noted that this code has identical pre and intra-service time and slightly higher post-service time justifying the slightly higher work value. The RUC also considered comparisons with CPT code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.* (work RVU=3.17, pre-service time of 7 minutes, intra-service time of 45 minutes, and immediate post-service time of 15 minutes) and CPT code 99235 *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.* (work RVU=3.24, pre-service time of 14 minutes, intra-service time of 50 minutes, and immediate post-service time of 19.5 minutes). **The RUC recommends a work RVU of 3.44 for CPT code 99483.**

Practice Expense:

A detailed discussion occurred where it was considered that this service is different than most in terms of PE, because it can be billed every 180 days, and the RUC took into account potential overlap with E/M services that could be billed during this time period. The clinical staff type was revised so that, rather than a RN/CORF (L051C), the standard clinical staff type of a RN/LPN/MTA (L037D) is utilized, except where the scope of practice and clinical abilities of a RN is required, and in those instances, a RN (L051A) was recommended. In the pre-service period, the RUC approved that the standard three minutes for a phone call was not adequate and determined that it should be 6 minutes to ensure that the caregiver is aware and has available all the appropriate reports and paperwork that should accompany the patient to the visit. In the service period, there is 15 minutes of clinical staff time overlapping with 15 minutes of the physician work, because both are in the exam room with the patient and the caregiver. Following that, the clinical staff and the caregiver leave the exam room while the physician stays with the patient and completes the physical exam. During this time, the clinical staff meets separately with the the caregiver for 15 minutes to discuss the care necessary for the patient and to assess if the caregiver is capable of providing for the needs of the patient. At the conclusion of this work, the physician and the clinical staff meet for 4 minutes to briefly discuss the care plan, and

the clinical staff proceeds to draft the care plan while the physician does other work. The physician and clinical staff then reconvene to meet with the caregiver and patient to share the plan and educate specifically on medical and medication issues for 7 minutes. Then the physician will leave, and the clinical staff meets with patient and caregiver for an additional 10 minutes. During this time, the patient and caregiver have time to ask additional questions and review the care plan again. It is typical that once the physician leaves, there are logistical questions or repeated items. Educating the patient and caregiver is complex, as the caregiver is going to need to agree to do things and ask questions; this time is necessary so as not to rush and ensure the care plan can will be carried out. In the post-service period, 9 minutes of clinical staff time was allocated for 3 phone calls, modeled after CPT code 99205. The RUC approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

Diagnostic Bone Marrow Aspiration and Biopsy (Tab 6)

David Regan, MD (ASCO); Elizabeth Blanchard, MD (ASCO);

Michael Lill, MD (ASBMT); Jonathan Myles, MD (CAP)

Facilitation Committee #3

In the NPRM for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 38221 was one of the services identified in this screen.

Prior to the January 2016 RUC meeting, the specialty societies notified the RUC of their plan to submit a code change application to the CPT Editorial Panel to revise these services. The societies indicated their plan to improve nomenclature for these codes (ie diagnostic vs therapeutic use) and to create a CPT code to replace code G0364. At the February 2016 CPT meeting, the CPT Editorial panel created one new code to replace the existing G code and revised the descriptors for CPT codes 38220 and 38221.

Compelling Evidence

The specialty societies presented compelling evidence for code 38220. They noted that the physician work and times have changed relative to the amount and types of specimens that are obtained today which are greater in number than in 1995 when 38220 was discussed at the first Five-Year review. The specialty societies noted that due to advances and greater access to immunophenotyping techniques and simultaneous refinements in cytogenetic methods and molecular diagnostics, the number of tests performed has increased, necessitating more passes to obtain additional bone marrow aspirate and material. The RUC agreed with the specialty societies that, since this procedure was originally valued, the physician work has increased as multiple passes to obtain additional bone marrow aspirate and material are now necessary. Therefore, this service would meet the compelling evidence for both technique and physician time.

The specialty societies also noted that a flawed methodology was used in the previous valuation for this service as the code has a CMS/Other designation. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The RUC accepted that there is compelling evidence that both the amount of physician work and technique involved in performing 38220 has changed and that a flawed methodology was utilized when 38220 was originally valued.

38220 Diagnostic bone marrow; aspiration(s)

The RUC reviewed the survey results from 121 physicians and agreed with the societies on the following physician time components: a pre-service time of 15 minutes, an intra-service time of 20 minutes and a post-service time of 12 minutes.

The RUC reviewed the survey 25th percentile work RVU of 1.20 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 1.20, the RUC compared the survey code to XXX and MPC code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20, intra-service time of 20 minutes, total time of 50 minutes) and noted that both services involve a similar amount of physician work, have identical intra-service times and very similar total times. The RUC also reviewed 000-day global CPT code 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report*; (work RVU= 1.28, intra-service time of 20 minutes, total time of 50 minutes) and agreed that this reference code further supports a work RVU of 1.20 for the survey code. **The RUC recommends a work RVU of 1.20 for CPT code 38220.**

38221 Diagnostic bone marrow; biopsy(ies)

The RUC reviewed the survey results from 120 physicians and agreed with the societies on the following physician time components: 15 minutes of pre-service time, 20 minutes of intra-service time and 15 minutes of post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that an appropriate value for this service is between the survey median RVU of 1.80 and survey 25th percentile value of 1.20. To determine an appropriate work value, the RUC compared the survey code to XXX code 99315 *Nursing facility discharge day management; 30 minutes or less* (work RVU=1.28, intra-service time of 20 minutes, total time of 40 minutes) and noted that reference code involves similar physician work and has identical intra-service time relative to the survey code. Therefore, the RUC recommends a direct work RVU crosswalk from code 99315 to code 38221. To further support this recommendation, the RUC compared the survey code to 000-day global code 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report*; (work RVU= 1.28, intra-time of 20 minutes, total time of 50 minutes) and noted that both services involve a similar amount of physician work and have identical intra-service and total times. **The RUC recommends a work RVU of 1.28 for CPT code 38221.**

38222 Diagnostic bone marrow; biopsy(ies) and aspiration(s)

The RUC reviewed the survey results from 120 physicians and agreed with the societies on the following physician time components: 15 minutes of pre-service time, 30 minutes of intra-service time and 15 minutes of post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey respondents somewhat overvalued the work involved, with a 25th percentile RVU of 1.50. To determine an appropriate work value, the RUC compared the survey code to 000-day code 91022 *Duodenal motility (manometric) study* (work RVU= 1.44, intra-service time of 30 minutes, total time of 61 minutes) and noted that both services involve a similar amount of physician work and have identical intra-service times. Therefore, the RUC recommends a direct work RVU crosswalk from code 91022 to code 38222. To further support this recommendation, the RUC compared the survey code to XXX code 90832 *Psychotherapy, 30 minutes with patient and/or family member* (work RVU= 1.50, intra-service time 30 minutes

and total time of 45 minutes) and noted that both services have identical intra-service times and involve a similar amount of physician work. **The RUC recommends a work RVU of 1.44 for CPT code 38222.**

Global Period

At the April 2016 RUC meeting, the RUC questioned why the current global period for these procedures is XXX, while a 000-day global would seem more appropriate. The specialties concurred with the RUC that a 000-day global would be more appropriate. **The RUC recommends for CMS to convert CPT codes 38220, 38221 and 38222 to a 000-day global period. The RUC noted that the Committee's recommendations are not contingent on this global period change.** To facilitate CMS' evaluation of the global period change recommendation, this RUC recommendation includes both XXX and 000-day reference codes for each survey code.

Practice Expense

The clinical labor type was changed from the requested L051A RN to the more typical blend L037D RN/LPN/MTA with the exception of the intra-service time, as an RN typically assists the patient only with performing the procedure itself. The amount of milliliters for fixative in the supplies were also corrected. The amount of supplies included are adequate regardless and independent the number of passes and the amount of material that was obtained for each service in the family. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology

These services will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Chest X-Ray (Tab 7)

Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR)

In the Final Rule for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes 71010 *Radiologic examination, chest; single view, frontal* and 71020 *Radiologic examination, chest, 2 views, frontal and lateral*; were identified via this screen. The specialty elected to send the entire family of chest X-ray codes to the CPT Editorial Panel to modernize the reporting of these services. The CPT Editorial panel deleted all 9 existing codes in the chest X-ray family and created 4 new codes for reporting chest X-ray.

71045 *Radiologic examination, chest; single view*

The RUC reviewed the survey results from 86 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU and agreed that it would be appropriate to assign the new code the same work value (work RVU= 0.18) as the deleted code 71010 *Radiologic examination, chest; single view, frontal*. The RUC noted that this

deleted code 71010 was the most commonly performed single view chest X-ray code according to 2015 Medicare claims data; 99 percent of the volume for 71045 would have previously been reported using 71010. To justify a work RVU of 0.18, the RUC compared the survey code to 2nd key reference and MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that although both services have identical intra-service times and involve a similar intensity of work, the survey code has slightly less total time. The RUC also compared the survey code to CPT code 73501 *Radiologic examination, hip, unilateral, with pelvis when performed; 1 view* (work RVU= 0.18, intra-service time of 3 minutes and total time of 5 minutes) and noted that both services have identical physician times and involve a similar amount of physician work, further supporting a value of 0.18 for the survey code. **The RUC recommends a work RVU of 0.18 for CPT code 71045.**

71046 Radiologic examination, chest; 2 views

The RUC reviewed the survey results from 86 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.22 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.22, the RUC compared the survey code to CPT code 73502 *Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views* (work RVU= 0.22, intra-service time of 4 minutes, total time of 6 minutes) and 73521 *Radiologic examination, hips, bilateral, with pelvis when performed; 2 views* (work RVU= 0.22, intra-service time of 4 minutes, total time of 6 minutes). The RUC noted that all three services have identical intra-service and total times and involve similar amounts of physician work. **The RUC recommends a work RVU of 0.22 for CPT code 71046.**

71047 Radiologic examination, chest; 3 views

The RUC reviewed the survey results from 86 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute. The RUC noted that although 71047 has the same amount of survey time as 71046, the increased potential for disease and the increase in the complexity of the patient for the typical 3-view X-ray warranted a somewhat higher work RVU for 71047 relative to 71046. Also, the RUC noted that reviewing 3 views takes slightly more time than a 2 view X-ray, though the difference may only be in seconds which is a level of granularity not captured in the data.

The RUC reviewed the survey 25th percentile work RVU of 0.27 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.27, the RUC compared the survey code to top key reference code 73503 *Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views* (work RVU= 0.27, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services involve a similar amount of physician work and similar physician times. The RUC also reviewed CPT code 73522 *Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views* (work RVU= 0.29, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services involve a similar amount of physician work and similar physician times, confirming that a work RVU of 0.27 is appropriate for the survey code. **The RUC recommends a work RVU of 0.27 for CPT code 71047.**

71048 Radiologic examination, chest; 4 or more views

The RUC reviewed the survey results from 86 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU and agreed that it would be appropriate to assign the new code the same work RVU of deleted code 71030 *Radiologic examination, chest, complete, minimum of 4 views*, 0.31. The RUC noted that the majority of projected Medicare volume for 71048 is estimated to have previously been reported using 71030. To justify a work RVU of 0.31, the RUC compared the survey code to top key reference code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service times and involve a similar amount of physician work. The RUC also compared the survey code to CPT code 72052 *Radiologic examination, spine, cervical; 6 or more views* (work RVU= 0.36, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service times while the survey code involves somewhat less physician work in the post-service period, supporting a somewhat lower valuation. **The RUC recommends a work RVU of 0.31 for CPT code 71048.**

Practice Expense

A detailed discussion was convened regarding the typical clinical labor, supplies and equipment and site of service when CPT code 71045 is performed in the non-facility setting. The vast majority of the volume for this new code would have previously been reported using deleted code 71010. For the 437,000 Medicare claims in 2014 that were reported globally, the largest provider of these claims are independent providers in nursing homes, where the largest plurality are unskilled nursing homes that are not subject to the consolidated billing rules for Medicare Part A and the X-ray provider would have to get a contract from the nursing home. The service was evaluated based on the most typical scenario which is an independent provider wheeling a portable X-ray machine into an unskilled nursing home. Due to this typical scenario, the clinical labor time for acquiring the images was reduced to 2 minutes, the clinical labor time for cleaning the room and the equipment was reduced to 1 minute, the clinical labor time for reviewing exam with the interpreting physician was deleted. Also, the X-ray equipment was changed to EF041 Portable X-ray Machine and the equipment input for the basic radiology room was eliminated.

For CPT code 71048, the clinical labor time for acquiring the images was changed to 10 minutes to make the time in line with the other services in the family based on the number of views. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Abdominal X-Ray (Tab 8)

Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR)

In the Final Rule for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

CPT codes 74000 *Radiologic examination, abdomen; single anteroposterior view* and 74022 *Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* were identified via this screen. The specialty elected to submit the entire family of abdominal X-ray codes to the CPT Editorial Panel to modernize the reporting of these services. The CPT Editorial panel deleted 3 of the 4 existing codes in the abdominal X-ray family and created 3 new codes for reporting abdominal X-ray.

74018 *Radiologic examination, abdomen; 1 view*

The RUC reviewed the survey results from 76 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU, 0.19, and agreed that the physician work required to perform this new code is the same work as deleted code 74000 *Radiologic examination, abdomen; single anteroposterior view* (work RVU=0.18). The RUC noted that the vast majority of projected Medicare volume for 74018 is estimated to have previously been reported using 74000. To justify a work RVU of 0.18, the RUC compared the survey code to MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that although both services have identical intra-service times and involve a similar intensity of work, the survey code has slightly less total time. The RUC also compared the survey code to 2nd key reference code 73501 *Radiologic examination, hip, unilateral, with pelvis when performed; 1 view* (work RVU= 0.18, intra-service time of 3 minutes and total time of 5 minutes) and noted that both services have identical physician times and involve a similar amount of physician work, further supporting a value of 0.18 for the survey code. **The RUC recommends a work RVU of 0.18 for CPT code 74018.**

74019 *Radiologic examination, abdomen; 2 views*

The RUC reviewed the survey results from 76 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.23 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.23, the RUC compared the survey code to top key reference and MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that they survey code has more intra-service times and involves a similar intensity of physician work. The RUC also compared the survey code to 2nd key reference code 72081 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view* (work RVU= 0.26, intra-service time of 5 minutes, total time of 7 minutes) and noted that with less intra-service and total time, a somewhat lower work value of 0.23 is justified for the survey code. **The RUC recommends a work RVU of 0.23 for CPT code 74019.**

74021 *Radiologic examination, abdomen; 3 or more views*

The RUC reviewed the survey results from 76 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute. The RUC noted that although 74021 has the same amount of survey time as 74019, the increased potential for disease and the increase in the complexity of the patient for the typical 3-view X-ray warranted a somewhat higher work RVU for 74021 relative to 74019. Also, the RUC noted that reviewing 3 views takes slightly more time than a

2 view X-ray, though the difference may only be in seconds which is a level of granularity not captured in the data.

The RUC reviewed the survey 25th percentile work RVU of 0.27 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.27, the RUC compared the survey code to top key reference code 73503 *Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views* (work RVU= 0.27, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services involve a similar amount of physician work and similar physician times. The RUC also reviewed 2nd key reference code 73522 *Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views* (work RVU= 0.29, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services involve a similar amount of physician work and similar physician times, confirming that a work RVU of 0.27 is appropriate for the survey code. **The RUC recommends a work RVU of 0.27 for CPT code 74021.**

74022 Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest

The RUC reviewed the survey results from 76 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.32 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.32, the RUC compared the survey code to top key reference code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service times and involve a similar amount of physician work. The RUC also compared the survey code to 2nd key reference code 72052 *Radiologic examination, spine, cervical; 6 or more views* (work RVU= 0.36, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service times while the survey code involves somewhat less physician work in the post-service period, supporting a somewhat lower valuation. **The RUC recommends a work RVU of 0.32 for CPT code 74022.**

Practice Expense

A discussion was convened, noting that although deleted code 74000 was identified as typically an emergent service, the corresponding new code, 74018 does not typically require any pre-service clinical labor time. It was confirmed that the inclusion of SB026 gown is warranted. The amount of time for acquiring images was decreased to 6 minutes for 74019 to ensure that there is a logical progression of 3 minutes per view. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Pulmonary Diagnostic Tests (Tab 9)

Alan Plummer, MD (ATS); Robert DeMarco, MD (CHEST)

Facilitation Committee #1

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by

specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 94620 was identified via this screen.

In January 2016, the specialty societies explained that they submitted a Code Change Application (CCA) for the February 2016 CPT Editorial Panel meeting as CPT codes 94620 and 94621 required revisions that would allow the survey respondents to better value these services. Code 94620 described two different tests commonly performed for evaluation of dyspnea, the six minute walk test as well as pre-exercise and post-exercise spirometry. These tests are entirely different and should be described with two separate codes. In addition, code 94620 described a “simple” pulmonary exercise test and code 94621 a “complex” pulmonary exercise test. The testing described in 94621 is commonly called a cardiopulmonary exercise test (CPET) and not a complex pulmonary exercise test as it is currently labeled in CPT 2016. Code 94621 includes the measurement of minute ventilation and exhaled gases in addition to heart rate, oximetry and ECG monitoring. As such, it should not be included as part of the family of less complex exercise tests. The RUC referred CPT code 94620 to the CPT Editorial Panel. In February 2016, the CPT Editorial Panel deleted code 94620, added two new codes 94617 & 94618 to report an exercise test for bronchospasm, and revised code 94621 to describe a cardiopulmonary exercise test.

The RUC discussed the survey results for CPT codes 94617, 94621 and 94618 and determined that the survey respondents indicated immediate post-procedure physician time was not representative of the time required to perform this service. The RUC noted that the description of immediate post-procedure physician work described the same intensity for each of the three services but was not represented the same across all three services by the survey respondents.

The standard survey instrument did indicate that the survey respondents should capture the interpretation and report work in the intra-service time period as is typical for XXX global services, but the specialty society contends that the survey respondents did not appear to capture the physician time correctly. The RUC recommends that the specialty societies resurvey codes 94617, 94621 and 94618 with the same exact survey instrument (the current standard RUC survey for imaging and tests).

The RUC recommends that CPT codes 94620, 94617, 94621 and 94618 be re-surveyed for the October 2016 RUC meeting.

Parent, Caregiver-focused Health Risk Assessment - PE Only (Tab 10)

Jennifer R. Aloff, MD (AAFP); Steven E. Krug, MD (AAP)

The CPT Editorial Panel added two new codes, 96160 *Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument* and 96161 *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*, to the Medicine section of CPT and deleted 99420 *Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)* from the Evaluation and Management (E/M) section.

At the January 2016 RUC meeting, the specialty societies recommended that this family of codes be surveyed for practice expense for the April 2016 RUC meeting. For their presentation in January, the specialty societies used an expert panel to determine the staff

time and medical supplies, the same process that is used for most PE recommendations. The Practice Expense Subcommittee noted that PE surveys have been utilized on occasion and it would be possible for a PE survey to be created to review these services. The specialty societies noted their concern that the PE Subcommittee's recommendation of five minutes of clinical staff time in January 2016 undervalues the services and would like the data of a PE survey in order to either verify the PE Subcommittee's recommendation or indicate that more time is appropriate. The RUC agreed that these are important services and it is critical to get the PE inputs correct.

The specialty societies developed and administered a practice expense survey for the April 2016 RUC meeting. The PE Subcommittee and the RUC reviewed the survey results from 24 pediatricians and family physicians and noted that the survey 25th percentile of 96160 is 6 minutes clinical staff time and the survey 25th percentile of 96161 is 8 minutes clinical staff time. The RUC agreed with the specialty societies that a blend of the survey 25th percentiles for both codes, for a clinical staff time of 7 minutes, appropriately accounts for the clinical staff activities required to perform each code. The specialty societies clarified that they are recommending the survey 25th percentile for each clinical staff activity except *collate and score data elements on assessment in advance of physician's exam*. For this clinical staff activity, the survey respondents reported 0 minutes for 96160 and 2 minutes for 96161. The specialty societies recommended the average between the survey 25th percentiles for this clinical labor activity, or 1 minute of clinical labor time. The breakdown of time is *explain purpose of assessment to patient/caregiver and answer questions*, 2 minutes; *remain in exam room with patient/caregiver exclusive to completion of assessment*, 2 minutes; *collate and score data elements on assessment in advance of physician's exam* 1 minutes; and *scan assessment or enter data elements and total score into electronic health record*, 2 minutes. All clinical staff activities are performed by a *Medical/Technical Assistant (L026A)*. A PE Subcommittee member asked why the Beck Depression Inventory, Second Edition (BDI-II), was not recommended as a supply item as it was at the January 2016 RUC meeting, and the specialties explained that survey respondents reported using a free assessment tool, often provided as part of the electronic medical record. The specialty societies agreed that 2 sheets of *paper, laser printing (each sheet) (SK057)* to print the assessment tool is the only supply item needed for these services. **The RUC recommends the direct practice expense inputs as recommended by the specialty societies and approved by the Practice Expense Subcommittee.**

XI. CMS Request/Relativity Assessment Identified Codes

Anesthesia for Intestinal Endoscopic Procedures (Tab 11) **Marc Leib, MD (ASA)**

In the Final Rule for 2016, CMS stated that the anesthesia procedure codes 00740 *Anesthesia for procedure on gastrointestinal tract using an endoscope* and 00810 *Anesthesia for procedure on lower intestine using an endoscope* are used for anesthesia furnished in conjunction with lower GI procedures. In reviewing Medicare claims data, CMS noted that a separate anesthesia service is now reported more than 50 percent of the time when several types of colonoscopy procedures are reported. Given the significant change in the relative frequency with which anesthesia codes are reported with colonoscopy services, CMS believes the base units of the anesthesia services should be reexamined. Therefore, CMS proposed to identify CPT codes 00740 and 00810 as potentially misvalued. The RUC reviewed CPT codes 00740 and 00810 in January 2016 and recommended:

1. An interim base unit of 5 for code 00740 and 00810 and notes the comparison to the RUC recommended values for moderate sedation, 991X4 and 991X6, results in a work RVU equivalent that is only slightly higher than moderate sedation service of the same number of minutes.
2. Referral to the Research Subcommittee for review of the vignettes and to develop a method on how to review the survey data to value these services. The specialty societies should revise the vignette for the typical patient receiving anesthesia for an EGD, CPT code 00740, and for a patient receiving anesthesia for a colonoscopy (45378), CPT code 00810.
3. Resurvey 00740 and 00810 for the April 2016 RUC meeting.

In April 2016, an Ad Hoc Anesthesia Workgroup was formed to discuss the issues surrounding these services. The specialty society stated and the Workgroup agreed that CPT codes 00740 and 00810 are too broad in the range of endoscopic procedures covered under each code and should be referred to the CPT Editorial Panel September 29-October 1, 2016 meeting to request a new family of anesthesia codes to describe anesthesia for GI endoscopic procedures. The revised codes will specifically identify those patients undergoing both upper and lower gastrointestinal endoscopic procedures. **The RUC recommends CPT codes 00740 and 00810 be referred to CPT to better define these services.**

The Anesthesia Workgroup also recommended an educational presentation be provided to the RUC on the existing survey and valuation process for anesthesia services since it has not been validated or used for a survey since 2007, including a specific example of how the data from a survey are used to value an anesthesia service.

Fine Needle Aspiration (Tab 12)

Peter Manes, MD (AAO-HNS); Zeke Silva III, MD (ACR); Charles Mabry, MD (ACS)

Following publication of the 2014 Final Rule, the RUC solicited feedback from specialty societies regarding CPT codes potentially impacted by the OPPI/ASC payment cap proposal. Specialty societies looked over the list of 211 codes identified by the proposal and indicated which services they have an interest in reviewing. The RUC recommended developing practice expense (PE) inputs only for the subset of codes identified by specialty societies, grouped by specialty, at the April 2014 RUC meeting. In the 2016 Final Rule, CMS noted their concerns about implementing PE inputs without the corresponding work being reviewed. The RAW analyzed the 58 services that the RUC submitted PE recommendations for and determined that one or more of the following is true of many of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. If you apply these criteria only 6 codes remain. CPT code 10021 *Fine needle aspiration; without imaging guidance* met those criteria. CPT Code 10022 *Fine needle aspiration; with imaging guidance* was also identified under the CMS High Expenditure Procedure list.

The specialty societies provided two reasons why these codes need to be referred to the CPT Editorial Panel prior to conducting a RUC survey. First, both codes need clarifying language stating that they should be reported per lesion rather than for every pass on the same lesion. Second, CPT code 10022 is reported with 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* more than 75% of the time together and a bundled code solution will be developed. The specialty societies also requested that these two codes be moved to the 2019 CPT cycle, due to the high workload currently involving the societies. **The RUC recommends that CPT**

codes 10021 and 10022 be referred to the CPT Editorial Panel for the February 2017 meeting.

Acne Surgery (Tab 13)

Daniel M Siegel, MD (AAD); Adam Rubin, MD (AAD)

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and CPT code 10040 was identified.

10040 Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)

The RUC reviewed the survey results from 35 practicing dermatologists and agreed on the following physician time components: pre-service evaluation time of 3 minutes, with a reduction of 4 minutes to account for the reporting of an Evaluation and Management service on the same date, pre-service positioning time of 1 minute, to position the patient to expose and stabilize the multiple lesions to be treated and pre-service scrub, dress, wait time of 1 minute for the physician to put on the mask and prepare the patient's treatment area. Finally, the RUC discussed the medical necessity for an Evaluation and Management (99212) within the 10 day global period for this code. The typical patient is a teenager who will often need to return due to the management of medication, including changing topical treatment and/or adjusting retinoid dosage. Patients also may have new lesions that need to be treated within the global period. The specialty society also noted that the survey respondents indicated a 99213 office visits was typical, but the expert panel reduced the visit to a 99212 to better align with clinical appropriateness.

The RUC reviewed the specialty society's recommended work value and agreed that the survey's 25th percentile work RVU of 0.91, lower than the current work RVU is, is appropriate. To justify a work RVU of 0.91, the RUC compared the survey code to second key reference service 17111 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions* (work RVU= 0.97, intra time= 10 minutes) and agreed that since both these codes have identical intra-service time and comparable physician work, both services should be valued similarly. The RUC also noted that the median intra-service time of 10 minutes is a reduction of 4 minutes from the current intra time. However, the current time source is Harvard, which assigned time for this service over 25 years ago, in a process that did not rise to the robust survey requirements currently followed by the RUC. The RUC also determined that there has been no change in the intensity of this procedure. The lowering of the IWP/UT to 0.0265 is a direct result of the inclusion of a full 99212 post-operative Evaluation and Management service. Previously a half-day 99212 service was included by the Harvard study, whereas the RUC and CMS no longer include fractions of post-operative office visits. **The RUC recommends a work RVU of 0.91 for CPT code 10040.**

Practice Expense:

The clinical labor time duplicative of the Evaluation and Management code that is typically performed with this service was removed. Also, 1 *pack, minimum multi-specialty visit*, SA048 was added for a total of 2, 1 for the service and one for the post-operative visit and corrected the type of scalpel used. Additionally, equipment item *mayo stand*, EF015 was added. The RUC approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Muscle Flaps (Tab 14)

Mark Villa, MD (ASPS); Charles Mabry, MD (ACS)

In October 2015, CPT codes 15732 and 15734 were identified under the High Level E/M screen for services with Medicare utilization greater than 10,000 that has a 99214 included in the global period. The RAW requested that the specialty societies submit an action plan to justify the 99214 visit and review if the family of services also have a 99214 included in the global periods. The RUC noted that a 99214 office visit is included for 15732 and 15736 but not included in the other codes in this family.

15732 Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)

The specialty societies explained that, as also indicated by the three previous surveys for this procedure, the new survey results indicate the typical patient will have inpatient status (72%) and the typical length of stay will be four days. As in the past, this conflicts with the Medicare utilization data that shows the primary place of service as the outpatient hospital setting. Therefore, the specialty societies determined that the code needs to be referred to the CPT Editorial Panel to better differentiate and describe the work of large flaps performed on patients with head and neck cancer who will have inpatient status. This is in contrast to smaller flaps that may be accomplished in an office or outpatient setting and to differentiate from procedures that would be best coded by the adjacent tissue transfer codes. In addition, during the discussion, CMS requested that CPT code 15731 be added to the family of codes for the subsequent RUC review. **The RUC recommends referral of CPT code 15732 to the CPT Editorial Panel. Additionally, CPT code 15731 will be added as part of the family for review.**

15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk

Prior to reviewing the survey data for this procedure, the RUC considered compelling evidence that the current work RVU of 19.86 may be incorrect. The specialty societies detailed two compelling evidence arguments. First, a flawed methodology was used in the previous valuation. During the last valuation at the third Five-Year Review, plastic surgery was the only specialty to conduct a survey, and only 21 responses were collected. At that time, plastic surgery represented approximately 80% of the total utilization of CPT code 15734. Currently, 2015 Medicare utilization shows plastic surgery and general surgery as equally performing this service (43% and 42%, respectively). Furthermore, accounting for other specialties similar to general surgery (colorectal, surgical oncology, vascular, etc.), who are performing the procedure for the same indications, the dominant provider has shifted. Second, the patient population and technique has changed. General surgeons are now performing this procedure to close large, complex abdominal defects that cannot be closed primarily. This is a new surgical procedure that was not performed at the time of the last review. During the previous valuation, plastic surgeons were primarily using this procedure to repair chest wall defects. Given this information, the RUC approved compelling evidence that the current work value for CPT code 15734 may be incorrect.

The RUC reviewed the survey results from 41 general and plastic surgeons and recommends the following physician time components: pre-service time of 75 minutes, intra-service time of 180 minutes and immediate post-service time of 30 minutes. The RUC agreed to add 12 minutes of positioning time above the standard package because the typical patient

undergoing a latissimus muscle flap will be positioned supine, then lateral as the procedure progresses. The typical patient undergoing a rectus abdominis flap will require additional time related to a vacuum assisted dressing in place that will need to be taken down. The RUC also recommend the following post-operative visits: four hospital visits (1 x 99233, 2 x 99232, 1 x 99231), one discharge day management service 99238, and five office visits (1 x 99214, 2 x 99213, 2 x 99212). The RUC discussed the need for a higher level Evaluation and Management service (99214) for the first post-operative visit and agreed it was appropriate. The patient has an extensive dressing (for both the flap and the donor site) that has to be taken down. The process is complex and intense due to concern about not disturbing the blood supply to the flap, as well as not disturbing the skin graft. Finally the RUC noted the increase to two 99232 hospital visits in the global period and confirmed that this visit is in fact typical and was captured, by the survey respondents, as performed in the post-operative period and not on the same day of the surgery.

The RUC reviewed the specialty societies' recommendation and agreed that the survey median work RVU of 23.00 reflects the additional intra-operative time and additional postoperative hospital work for CPT code 15734. To justify a work RVU of 23.00, the RUC compared the surveyed code to the primary key reference code 22905 *Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater* (work RVU= 21.58, intra time= 150 minutes) and determined that code 15734 is similar in time and intensity. The RUC also considered the second key reference service 27364 *Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater* (work RVU= 24.49, intra time= 180 minutes) and agreed that CPT code 15734 is more work and should be valued higher. Finally, the RUC noted that the increase in work RVUs is further substantiated by the increase in intra-service time, from 163 minutes to 180 minutes, and total time, from 524 minutes to 596 minutes. **The RUC recommends a work RVU of 23.00 for CPT code 15734.**

15736 Muscle, myocutaneous, or fasciocutaneous flap; upper extremity

The RUC reviewed the survey results from 46 practicing general, plastic, and hand surgeons and recommends the following physician time components: pre-service time of 72 minutes, intra-service time of 150 minutes and immediate post-service time of 30 minutes. The RUC agreed to add 9 minutes of positioning time above the standard package to monitor and/or assist with patient positioning, including padding of bony prominences, application of thermal regulation drapes, assessing position of extremities and head and adjusting as needed, positioning the patient's arm on the hand surgery table, applying a sterile tourniquet to the proximal arm, elevating the arm and exsanguinating the arm, and inflating the pneumatic tourniquet. The RUC noted that total positioning time of 12 minutes is consistent with many other recently reviewed upper extremity procedures. The RUC also recommend the following post-operative visits: one-half discharge day management service 99238 that is consistent with outpatient facility status and five office visits (1 x 99214, 3 x 99213, 1 x 99212). The RUC discussed the need for a higher level Evaluation and Management service (99214) for the first post-operative visit and agreed it was appropriate. The patient's comfort and adherence to the postoperative regimen is discussed. The extremity edema, circulation, sensation and motor function are assessed. The splint is removed, but the arm is supported. The superficial dressing is removed. The viability of the flap is assessed. The wound is checked for any sign of infection. The non-stick dressing covering the skin graft is very carefully separated from the graft while protecting the graft with cotton swabs. A new non-stick dressing is applied to the flap. A new dressing is applied to the arm. The donor site is evaluated and redressed. Pain is assessed and adjustments to medications are made as needed. The patient care plan is reviewed with the patient and family. Communication with the referring physician is

completed. The medical record is completed. It is typical for this visit to take upwards of one hour.

The RUC reviewed the specialty societies' recommendation and agreed that the current work RVU of 17.04, which is between the survey's 25th percentile and median work values, is appropriate. The RUC agreed with the specialties that the work and total time has not changed; the intra-operative time is the same and the facility work has shifted to higher level office work. To justify a work RVU of 17.04, the RUC compared the surveyed code to the primary key reference code 24160 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components* (work RVU= 18.63, intra time= 120 minutes) and agreed that while code 15736 has 30 additional minutes of intra-service time, the reference code has more post-operative visits and is a more intense procedure. Therefore, the surveyed code is valued appropriately slightly less than the key reference service. Additionally, the RUC reviewed a broad range of 090 day global outpatient procedures recently reviewed by the RUC and agreed that the current work RVU of 17.04 appropriately fits in this range. Specifically, CPT codes 49655 *Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated* (work RVU= 16.84, intra time= 150 minutes) and 42415 *Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve* (work RVU= 17.16, intra time= 150 minutes) offer appropriate brackets around the recommended value. **The RUC recommends a work RVU of 17.04 for CPT code 15736.**

15738 Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

The specialties presented compelling evidence of a flawed methodology in the previous survey. The specialties indicated that the survey instrument in 1995 requested total hospital time and number of visits, but not level of visits. Then, when level of visits was necessary for the first five-year review of practice expense, a CMS contractor transformed the postoperative time into visit levels using an algorithm based on intra-service time. This resulted in all low level hospital and office visits being assigned to code 15738. The current survey indicates that the hospital and office visit work was underestimated and that increases in the value for E/M codes over the years were not correctly incorporated in the global code value for 15738. The RUC rejected this compelling evidence citing that the RUC survey has evolved over time and that an old RUC survey instrument is not compelling evidence of a flawed methodology.

The RUC reviewed the survey results from 39 plastic surgeons and recommends the following physician time components: pre-service time of 70 minutes, intra-service time of 150 minutes and immediate post-service time of 30 minutes. The RUC agreed to add 12 minutes of positioning time above the standard package to adequately position the patient with the leg extended lateral or the patient positioned prone. In addition, these patients will require a significant amount of effort to transfer from the hospital bed to the operating room bed because there is commonly a vacuum-assisted dressing in place that will need to be taken down. The RUC also recommend the following post-operative visits: four hospital visits (2 x 99232, 2 x 99231), one discharge day management service (99238), five office visits (4 x 99213, 1 x 99212).

The RUC reviewed the survey respondents' estimated physician work values and noted that the current work RVU of 19.04, slightly above the 25th percentile work RVU of 19.00 should be maintained since compelling evidence was not accepted. The RUC compared the surveyed code to the second key reference code 22905 *Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater* (work RVU= 21.58, intra time= 150 minutes) and agreed that while both services have identical intra-service time, the reference code has less

total time, but may be more intense. **The RUC recommends a work RVU of 19.04 for CPT code 15738.**

Practice Expense:

The large amounts of supplies (eg, gauze, etc. were reviewed). However, the specialties explained that the wounds are large and complex for these patients and the large quantities of supplies are appropriate. The specialties provided details of quantities required on a visit by visit basis. The RUC approved the direct practice expense inputs as submitted by the specialty without modification and reviewed and approved by the PE Subcommittee.

Mastectomy (Tab 15)

Eric Whitacre, MD (ASBrS); Charles Mabry, MD (ACS)

In October 2015, CPT code 19303 was identified by a screen in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, but included inpatient hospital Evaluation and Management services within the global period. This service was also identified under the High Level E/M screen for services with Medicare utilization greater than 10,000 that has a 99214 included in the global period.

19303 Mastectomy, simple, complete

The RUC reviewed the survey results from 148 general and breast surgeons and recommend the following physician time components: pre-service time of 58 minutes, intra-service time of 90 minutes and immediate post-service time of 30 minutes. The RUC agreed with the specialties and a majority of the survey respondents (87%) who indicated that the typical mastectomy patient will stay overnight or be admitted as inpatients. The RUC also agreed that the typical patient will require a E/M visit later the same day, however, because CMS does not allow reporting inpatient E/M codes for procedures that will have a facility status of outpatient, 10 minutes was added to the survey immediate post-time to reflect face to face time for a visit later on the same day, per CMS policy. The RUC also recommends the following post-operative visits in the surgical global package: one-half discharge management service (99238) (per CMS policy for codes with a facility status of outpatient), three office visits (2 x 99213 and 1 x 99214). The specialties explained that the 99214 office visit is appropriate because this procedure requires post-discharge management of a large, complex wound, including drains. At the second visit after discharge, the surgeon will take down dressings; evaluate the wound for infection; remove the drain; redress the wound; assess the extremity for edema, circulation, sensation and motor function; assess the pain score and order medication, as necessary; review pathology results and marker studies, and possible genetic analysis with the patient, family, referring physician(s), and appropriate consultants; discuss the need for postoperative adjuvant chemotherapy, post mastectomy radiation and/or hormonal therapy based on the pathology findings; discuss case with oncologist, and radiation oncologist if indicated, and prepare documents for transmission to their offices; answer patient and family questions and reinforce instructions on wound care, activity, and bathing; enter progress notes into medical record; and discuss progress with PCP. This post-surgical assessment, planning and discussion are time-intensive, with the typical visit lasting at least 30 minutes. The RUC agreed that this work is appropriately represented by 99214 for the typical patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the median work RVU of 15.00 accurately accounts for the physician work required for CPT code 19303. To justify a work RVU of 15.00, the RUC compared the surveyed code to key reference service 19302 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy*

(work RVU= 13.99, intra time= 100 minutes) and agreed that the surveyed code is a more intense and complex surgical procedure. The specialties noted that although the CPT descriptor for 19303 states "simple", the procedure is a "total" mastectomy. Compared to lumpectomy with axillary dissection (CPT code 19302), the procedure is in a completely different tissue plane with different risks - mostly involving control of tributary blood vessels along the sternal border and the lateral thoracic artery and vein in the axilla, which can result in substantial bleeding. An additional difference between these two procedures is that patients undergoing code 19302 will almost always go home the same day, whereas the patients undergoing code 19303 will almost always stay overnight or be admitted for several days. This difference reflects increased post-operative work on the day of the procedure.

Finally, the RUC reviewed several other surgical 90-day global codes with 90 minutes of intra-service time, performed as outpatient procedures, and agreed that a work RVU of 15.00 is appropriate relative to these comparable services. Specifically, CPT codes 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU= 15.00) and 58571 *Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)* (work RVU= 15.00) offer appropriate cross-references to the recommended value. **The RUC recommends a work RVU of 15.00 for CPT code 19303.**

Practice Expense:

The RUC approved the direct practice expense inputs as submitted by the specialty without modification and reviewed and approved by the PE Subcommittee.

Work Neutrality

The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Injection for Knee Arthrography (Tab 16)

Zeke Silva III, MD (ACR)

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified. CPT code 27370 was also identified as a service on the high volume growth screen with Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and the CMS High Expenditure Codes list in the Final Rule for 2016.

This service was previously reviewed in January 2014, in which the specialty societies noted that, at the February 2014 CPT Editorial Panel meeting, a Code Change Proposal (CCP) was submitted to address the high growth of this code. The Panel approved editorial revisions replacing the term "procedure" for "of contrast." This revision to the descriptor clarifies that the correct use of 27370 is to describe the injection of contrast into the knee joint space for arthrography only. The specialty societies noted that the high volume growth for this procedure is likely due to its being reported incorrectly as arthrocentesis or aspiration. The correct reporting of those services is CPT code 20610 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance* (work RVU= 0.79).

27370 Injection of contrast for knee arthrography

The specialty society indicated that CPT code 27370 was initially scheduled to be surveyed for the October 2016. However, this code was put on the Level of Interest (LOI) for the April 2016 RUC meeting. The specialty society still intends to survey this code for the following

meeting in October 2016. **The RUC recommends deferral to October 2016 for CPT code 27370.**

Application of Rigid Leg Cast (Tab 17)

**Timothy Tillo, DPM (APMA); Pete Mangone, MD (AOFAS);
William Creevy, MD (AAOS); John Heiner, MD (AAOS)**

In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and code 29445 was identified. In January 2016 the RAW indicated that the dominant provider has changed, there is high volume growth and it was surveyed more than 10 years ago.

29445 Application of rigid total contact leg cast

The RUC reviewed the survey results from 59 practicing physicians and agreed with the following time components: pre-service time of 23 minutes, intra-service time of 25 minutes and immediate post-service time of 10 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 1.78 is appropriate, which is below the survey 25th percentile (work RVU= 1.90). The RUC noted an increase in total time to 58 from current 50 minutes due to the appropriate pre-service package being used and the adjustment to include pre-service evaluation time of 13 minutes, pre-service position time of 5 minutes, and pre-service scrub, dress, and wait time of 5 minutes. The RUC discussed the intra-service time for this code to decipher if the physician is performing the application of the cast. It was determined that the cast requires precise application and it is imperative that the physician or podiatrist apply the cast, utilizing clinical staff to assist. The patient is prone with knee flexed at 90 degrees and ankle maintained in neutral position during application. Further, as the cast is applied, shaping is important to achieve total contact. It was noted that this patient population often suffer from diabetic ulcers and severe infections that put them at risk of an amputation. The management of foot ulcers requires offloading the wound. Offloading of the ulcerated area is imperative; requiring bed rest or footwear. Total contact casting for patients who are ambulatory has become the gold standard for off-loading. The RUC compared code 29445 to the primary key reference service 29450 *Application of clubfoot cast with molding or manipulation, long or short leg* (work RVU= 2.08, intra time= 20 minutes) and noted the physician work and time are comparable. **The RUC recommends a work RVU of 1.78 for CPT code 29445.**

Practice Expense:

A detailed discussion was convened that CPT code 29445 is a 0-day global code for the application of a rigid leg cast. CPT guidelines and CMS policy indicate that casting and strapping procedures include removal of cast or strapping. Therefore, 22 minutes for the physician and clinical staff to remove the cast on a subsequent date is included in the post-service period of the casting code. The RUC approved the direct practice expense inputs with minor modifications as approved by the PE Subcommittee.

Strapping Multi-Layer Compression (Tab 18)

**Timothy Tillo, DPM (APMA); Matthew Sideman, MD (SVS);
Charles Mabry, MD (ACS)**

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia

and Evaluation and Management services and services reviewed since CY 2010. CPT code 29580 *Strapping; Unna boot* was identified via this screen and 29581 *Application of multi-layer compression system; leg (below knee), including ankle and foot* was added as part of this family of services.

At the April 2016 RUC meeting, the specialty societies indicated that the vignettes were flawed. The specialty societies will be submitting revised vignettes to the Research Subcommittee for approval. Additionally, the Research Subcommittee will review an instructional note about precision in time by the specialty societies. CMS also indicated that the family should include three codes for the upper arm, CPT codes 29582, 29583, and 29584. However, the RUC found that these codes are performed by different specialties than those involved in this code group. The RUC decided CPT codes 29582, 29583, and 29584 should be placed on the LOI for the October RUC meeting, in addition to CPT codes 29580 and 29581, so that appropriate specialties could opt in to survey them. **The RUC recommends that the specialty societies revise the vignettes for CPT code 29580 and 29581 and resurvey for the October 2016 RUC meeting.**

Resection Inferior Turbinate (Tab 19)

Peter Manes, MD (AAO-HNS)

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data. CPT code 30140 was identified and recommended to be surveyed.

30140 Submucous resection inferior turbinate, partial or complete, any method

The RUC reviewed the survey responses from 166 otolaryngologists and determined that the current work RVU of 3.57, below the survey 25th percentile work RVU of 3.89, was validated. The RUC recommends 30 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 20 minutes of intra-service time, 15 minutes immediate post-service time, ½ day 99238 discharge day management and two 99213 Evaluation and Management office visits. The RUC noted that the previous physician time is Harvard valued over 25 years ago and should not be used in comparison to the current survey time.

The RUC compared the surveyed code to 67914 *Repair of ectropion; suture* (work RVU= 3.75, intra-service time of 20 minutes) as it has identical intra time and requires similar physician work to perform. The RUC also referenced CPT code 33282 *Implantation of patient-activated cardiac event recorder* (work RVU = 3.50 and 25 minutes intra-service time) to support the recommended work RVU and time for 30140 as it is a relative similar service.

This service is typically performed under general anesthesia in the outpatient hospital setting. Therefore, the RUC indicated that the ½ day discharge day management service is appropriate as the patient will still be discharged. The RUC agreed that two 99213 office visits are necessary in order to perform the following work:

- Visit #1: Examine patient, evaluating the incision site and nasal cavity for crusting, hematoma or synechiae. Clear nasal cavity of crusting. Assess for any complications including scarring or continued congestion. Discuss activity restrictions and maintenance of wound site in post-operative period, including use of nasal saline. Assess the need for topical medications to improve post-operative swelling.

- Visit #2: Examine patient, evaluating the incision site and nasal cavity for crusting or synechia. Assess scarring or continued congestion. Discuss resumption of usual activity. Assess need for further nasal saline. Assess the need for further topical medication use.

The RUC recommends a work RVU of 3.57 for CPT code 30140.

RUC Database Notation

The RUC recommends to flag CPT code 30140 as “do not use” for validation of work as this service has a negative IWPUR and should be changed from a 090 day global period to a 000-day global period.

Global Period

The RUC requests that CMS assign a 000-day global period to CPT code 30140 and it be resurveyed for October 2016.

Practice Expense

The standard 090-day direct practice expense inputs were reviewed for 30140 and the equipment minutes for *chair with headrest, exam, reclining*, EF008, *light, fiberoptic headlight w-source*, EQ170 and *suction and pressure cabinet, ENT (SMR)*, EQ234 were revised to account for monitoring the patient following the procedure, and added supply item, *pack, cleaning, surgical instruments SA043* to clean instruments. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Control Nasal Hemorrhage (Tab 20)

Peter Manes, MD (AAO-HNS)

In October 2015, the PE Subcommittee analyzed the 58 services that the RUC submitted PE only recommendations for and determined that one or more of the following is true of many of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. If you apply these criteria only 6 codes remain. The codes are 10021, 30903, 88333, 88334, 95812 and 95813. Code 30903 was identified and the specialty society identified 30901, 30905 and 30906 as part of the same family.

30901 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method

The RUC reviewed the survey results from 83 otolaryngologists and determined that the current work RVU and survey median of 1.10 was validated. The RUC reviewed the pre-service time and recommends 3 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by 14 minutes from the standard package. The specialty society indicated and the RUC agreed that 3 minutes for evaluation is necessary for the physician to obtain supplies and equipment (packing material and silver nitrate for cautery) and drape and gown for the patient which is not included in the E/M. The RUC agreed that 5 minutes of scrub/dress/wait time is necessary for the physician to scrub, obtain gown, shoe covers and eye shield. The RUC recommends the same intra-service time of 10 minutes and immediate post-operative time of 5 minutes.

The RUC compared CPT code 30901 (with 23 minutes total time) to the top two key reference services 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate*

procedure) (work RVU = 1.10 and 21 minutes total time) and 12011 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less* (work RVU = 1.07 and 24 minutes total time) and noted that the physician work, time and intensity for these are similar and valued appropriately. For additional support the RUC referenced similar services 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10 and 27 minutes total time) and 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* (work RVU = 1.10 and 27 minutes total time). **The RUC recommends a work RVU of 1.10 for CPT code 30901.**

30903 Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method

The RUC reviewed the survey results from 83 otolaryngologists and determined that the current work RVU of 1.54, between the survey 25th percentile 1.30 and median 1.80, was validated. The RUC reviewed the pre-service time and recommends 8 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by two minutes. The specialty society indicated and the RUC agreed that the additional 5 minutes for evaluation time compared to 30901 is necessary to prepare the patient for using the additional electrocautery equipment. Silver nitrate sticks are used for the limited cautery used in 30901, whereas for more extensive cautery (30903, 30905 and 30906), the physician uses bipolar electrocautery equipment. The RUC recommends intra-service time of 15 minutes and immediate post-operative time of 10 minutes. The RUC agreed with the specialty societies that the intra-service time is longer than 30901 to account for the additional monitoring time by the physician as this service is more noxious and is secondary to more significant bleeding. The specialty society noted that the previous intra-service time last valued in 1995 was excessive. The RUC agreed that 15 minutes of intra-service time is more appropriate in line with the intensity of work per unit of time (IWPUT) and in position relative to other comparable services. More patients receiving this service are on blood thinners and therefore have more significant bleeding; hence the service is more intense than it was previously. The increase in post-time compared to 30901 is also due to these patients with more extensive bleeding requiring more monitoring.

The RUC also noted that during the 1995 review the specialty society requested a higher work RVU of 2.50 with 30 minutes of intra-service time, which was also similar to the original Harvard intra-service time (10 minutes pre-time /28 intra-time/10 minutes post-time). In 1995 the specialty society presented that the physician work has changed due to increased risk of HIV and Hepatitis. Although this compelling evidence was not accepted to increase the work RVU at that time, the survey intra service times were approved, which may have allowed for the intra-service time to remain high at 30 minutes. The specialty society also noted that many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

The RUC compared CPT code 30903 (with 39 minutes total time) to the top two key reference services 31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* (work RVU = 2.60 and 48 minutes total time) and noted that the physician work and time is lower for the surveyed code and valued appropriately. For additional support the RUC referenced similar services 15271 *Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less*

wound surface area (work RVU = 1.50), 64447 *Injection, anesthetic agent; femoral nerve, single* (work RVU = 1.50) and 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU = 1.52) all which require the same intra-service time and similar physician work to perform. **The RUC recommends a work RVU of 1.54 for CPT code 30903.**

30905 *Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial*

The RUC reviewed the survey results from 78 otolaryngologists and determined that the current work RVU of 1.97, below the survey 25th percentile work RVU of 2.20, was validated. The RUC reviewed the pre-service time and recommends 8 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by two minutes. The specialty society indicated and the RUC agreed that the additional 5 minutes for evaluation time compared to 30901 is necessary to prepare the patient for using the additional electrocautery equipment. Silver nitrate sticks are used for the limited cautery used in 30901, whereas for more extensive cautery (30903, 30905 and 30906), the physician uses bipolar electrocautery equipment. The RUC recommends intra-service time of 20 minutes and immediate post-operative time of 10 minutes. The RUC agreed with the specialty societies that the intra-service time is longer than 30903 because for 30905 access to the area is more difficult, the work is more extensive and posterior bleeds are typically arterial, therefore controlling those are more challenging and require more time. The specialty society noted that the previous intra-service time last valued in 1995 was much longer than the current time for this procedure based on the rationale that the 1995 review occurred during a time when concerns about HIV and Hepatitis were at an all-time high. Given this, significantly more time was taken by clinicians to protect against exposure and contamination during procedures where extensive bleeding occurs. Over time, and as education and precautionary measures against contracting these viruses has grown, the time needed related to those concerns has decreased which is consistent with the decreased intra-service survey times that respondents indicated in the 2016 survey data. The RUC agreed that 20 minutes of intra-service time is more appropriate in line with the intensity of work per unit of time (IWPUT) and in position relative to other comparable services. The increase in post-time compared to 30901 is also due to these patients with more extensive bleeding requiring more monitoring.

The RUC also noted that during the 1995 review the specialty society requested a much higher work RVU of 4.50 with 48 minutes of intra-service time, which was also similar to the original Harvard intra-service time (14 minutes pre-time /39 intra-time/13 minutes post-time). In 1995 specialty society presented that the physician work has changed due to increased risk of HIV and Hepatitis. Although this compelling evidence was not accepted to increase the work RVU at that time, it may have allowed for the intra-service time to remain high at 48 minutes. The specialty society also noted that many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

The RUC compared CPT code 30905 (with 44 minutes total time) to the top two key reference services 31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* (work RVU = 2.60 and 48 minutes total time) and noted that the physician work and time is lower for the surveyed code and valued appropriately. For additional support the RUC referenced similar services 12005 *Simple repair of superficial*

wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm (work RVU = 1.97 and 25 minutes intra-service time) and 92960 Cardioversion, elective, electrical conversion of arrhythmia; external (work RVU = 2.25 and 15 minutes intra-service time) which require similar time and physician work to perform. **The RUC recommends a work RVU of 1.97 for CPT code 30905.**

30906 Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent

The RUC reviewed the survey results from 76 otolaryngologists and determined that the current work RVU of 2.45, below the survey 25th percentile work RVU of 2.54, was validated. The RUC reviewed the pre-service time and recommends 12 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by 9 minutes. The specialty society indicated and the RUC agreed that the additional 4 minutes for evaluation time compared to 30905 is necessary to obtain supplies such as syringes, alligator forceps and suction materials to take down the nasal packs that were already inserted and failed in 30905, while the patient is actively bleeding. Silver nitrate sticks are used for the limited cautery used in 30901, whereas for more extensive cautery (30903, 30905 and 30906), the physician uses bipolar electrocautery equipment. The RUC recommends intra-service time of 30 minutes and immediate post-operative time of 15 minutes. The RUC agreed with the specialty societies that the intra-service time is longer than 30905 because for 30906 the work is more extensive for this subsequent bleed, removing previous packing and requiring more time. The specialty society noted that the previous intra-service time last valued in 1995 was excessive, consistent with the rationale of why longer intra service times were appropriate in 1995 versus the 2016 review. The RUC agreed that 30 minutes of intra-service time is more appropriate in line with the intensity of work per unit of time (IWPUT) and in position relative to other comparable services.

The RUC also noted that during the 1995 review the specialty society requested a much higher work RVU of 5.00 with 60 minutes of intra-service time, which was also similar to the original Harvard intra-service time (15 minutes pre-time /45 intra-time/14 minutes post-time). In 1995 specialty society presented that the physician work has changed due to increased risk of HIV and Hepatitis. Although this compelling evidence was not accepted to increase the work RVU at that time, the survey intra service times were approved, which may have allowed for the intra-service time to remain high at 60 minutes. The specialty society also noted that many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

The RUC compared CPT code 30906 (with 30 minutes intra-service time) to the top two key reference services 31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* (work RVU = 2.60 and 20 minutes intra-service time) and noted that the physician work and time is similar and slightly more intense to perform for the surveyed code. For additional support the RUC referenced similar services 12016 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm* (work RVU = 2.68 and 30 minutes intra-service time) and 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78 and 30 minutes intra-service time) which require similar time and physician work to perform. **The RUC recommends a work RVU of 2.45 for CPT code 30906.**

Practice Expense

Modifications were made to the direct practice expense inputs to correct monitoring times to account for the 1:4 multi-tasking for the two anterior packing codes and the and 1:1 for the two posterior packing codes, deleted phone call duplicative to E/M and supplies and accounted for the gowning and draping of the patient due to bleeding. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Tracheostomy (Tab 21)

Peter Manes, MD (AAO-HNS); Charles Mabry, MD (ACS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. Code 31600 was identified through this screen and codes 31601, 31603, 31605, and 31610 were added as family codes for survey.

31600 Tracheostomy, planned (separate procedure);

The RUC reviewed the survey results from 66 general surgeons and otolaryngologists and determined that the survey 25th percentile work RVU of 5.56, lower than the current value, appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 30 minutes of intra-service time and 30 minutes of immediate post-operative time.

The RUC compared the surveyed code to the top two key reference services 32608 *Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU = 6.84 and intra-service time of 60 minutes) and 43210 *Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed* (work RVU = 7.75 and intra-service time of 60 minutes) and agreed that the survey respondents valued this service lower as it requires less physician work and time to perform, but is more intense and complex. Performing a tracheotomy carries the risk of serious complications including bleeding, damage to the trachea, subcutaneous emphysema, pneumothorax, and hematoma, any of which can compromise continued breathing and patient survival.

The RUC compared 31600 to MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU 6.75 and 45 minutes intra-service time) and agreed that a work RVU of 5.56 for 31600 correctly accounts for less intra-operative time, but greater intensity and complexity, as the RUC noted that 52352 was an endoscopic outpatient procedure on an otherwise healthy individual. Finally, the RUC reviewed the relative intra-operative intensity to other recently reviewed codes with similar intensity and agreed that 31600 was relatively as intense and complex. For additional support the RUC referenced comparable services 34834 *Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral* (work RVU = 5.34 and 30 minutes intra-service time) and 35476 *Transluminal balloon angioplasty, percutaneous; venous* (work RVU = 5.10 and 35 minutes intra-service time). **The RUC recommends a work RVU of 5.56 for CPT code 31600.**

**31601 Tracheostomy, planned (separate procedure); younger than 2 years
Compelling Evidence**

The specialty societies presented compelling evidence that the value for code 31601 was based on a flawed methodology. The specialty societies informed the RUC that Harvard reviewed code 31601 as a 090-day global code. In that study, the intra-operative work estimates were provided by only ten general otolaryngologists and the pre-and post-operative work were computed by algorithm. The specialty societies also noted that the 1992 Medicare Physician Payment Schedule indicated a 090-day global period for 31601 with a footnote that the work RVU was “gap-filled” by CMS. In the 1993 Medicare Physician Payment Schedule, the global period was changed to 000-day and the work RVU reduced without resurvey and without any discussion in the Federal Register text. The specialty societies further noted that, during the first five-year-review in 1995, a comment was made to CMS that the intra-operative work of 31601 was undervalued and the code was surveyed. However, in 1995, the society did not have the history of the CMS global period changes and “gap fill” changes in valuation for this low volume procedure. Therefore, the RUC concluded that the patient population and procedure had not changed since the Harvard review and the Harvard work RVU was maintained. The rejected survey data were entered into the RUC database several years later and were marked “do not use to validate for physician work” because the surveyed physician time did not correspond to the Harvard work RVU that the RUC maintained. The RUC accepted the compelling evidence of flawed methodology as presented.

The RUC reviewed the survey results from 33 otolaryngologists and determined that the median work RVU of 8.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 45 minutes of intra-service time and 30 minutes of immediate post-operative time.

The RUC compared the surveyed code to the top two key reference services 43274 *Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent* (work RVU = 8.58 and intra-service time of 68 minutes) and 43210 *Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed* (work RVU = 7.75 and intra-service time of 60 minutes) and agreed that this service is appropriately valued as it requires less time to perform but is more intense and complex. Performing a tracheotomy carries the risk of serious complications including bleeding, damage to the trachea, subcutaneous emphysema, pneumothorax, and hematoma, any of which can compromise continued breathing and survival. In addition, performing a tracheostomy in pediatric patients has added difficulty because a child's neck is anatomically different from an adult's neck in the following ways: The dome of the pleura extends into the neck and is thus vulnerable to injury. The trachea is pliable and can be difficult to palpate. The neck is short, and there is significantly less working space. The cricoid can be injured if it is not correctly identified. The RUC also determined that a work RVU of 8.00 for 31601 appropriately ranked relative to 31600, as 31601 is performed on a pediatric patient and is significantly more intense and complex and requires more physician time.

The RUC also agreed that code 31601 was more intense and complex than MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU = 7.50 and 60 minutes intra-service time) which includes a low intensity diagnostic endoscopy prior to a therapeutic procedure and which is an outpatient procedure on otherwise healthy patients. Finally, the RUC reviewed the relative intra-operative intensity to other recently reviewed codes with similar intensity and agreed

that 31601 was relatively as intense/complex. **The RUC recommends a work RVU of 8.00 for CPT code 31601.**

**31603 Tracheostomy, emergency procedure; transtracheal
Compelling Evidence**

The specialty societies presented compelling evidence that the value for code 31603 was based on a flawed methodology. The specialty societies informed the RUC that Harvard obtained estimates from both otolaryngologists and thoracic surgeons as a 090-day global code, however thoracic surgeons are not a primary provider of this service (less than 2%) and general surgeons (29%) were not included in the review. In addition, prior to implementation of the 1992 Medicare Physician Payment Schedule, the global period was changed from 090-day to 000-day and the work RVU reduced without any discussion in the Federal Register text. The specialty societies further noted that, during the first five-year-review in 1995, a comment was made to CMS that the intra-operative work of 31603 was undervalued and the code was surveyed. However, in 1995, the society did not have the history of the CMS global period changes and “gap fill” changes in valuation for this low volume procedure. Therefore, the RUC concluded that the patient population and procedure had not changed since the Harvard review and the Harvard work RVU was maintained. The rejected survey data were entered into the RUC database several years later and were marked “do not use to validate for physician work” because the surveyed physician time did not correspond to the Harvard work RVU that the RUC maintained. The RUC accepted the compelling evidence of flawed methodology as presented.

The RUC reviewed the survey results from 61 general surgeons and otolaryngologists and determined that the survey 25th percentile work RVU of 6.00 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes of pre-service evaluation, 5 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 30 minutes of intra-service time and 30 minutes of immediate post-operative time.

Although both 31603 and 31600 are both intense procedures, the RUC noted code 31603 is relatively more intense than a planned tracheostomy, code 31600. The RUC compared code 31603 to the top two key reference services 43274 *Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent* (work RVU = 8.58 and intra-service time of 68 minutes) and 32608 *Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU = 6.84 and intra-service time of 60 minutes) and agreed that 31603 requires less physician time to perform, but is more intense and complex. Performing a tracheostomy carries the risk of serious complications including bleeding, damage to the trachea, subcutaneous emphysema, pneumothorax, and hematoma, any of which can compromise continued breathing and survival. Furthermore, in this case, the airway is not secured during the performance of the procedure, increasing the intensity and complexity.

For additional support the RUC referenced comparable services 34834 *Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral* (work RVU = 5.34 and 30 minutes intra-service time); 36222 *elective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed* (work RVU = 5.53 and 40 minutes intra-service time) and MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or*

manipulation of calculus (ureteral catheterization is included) (work RVU 6.75 and 45 minutes intra-service time) and agreed that a work RVU of 6.00 for 31603 correctly accounted for less intra-operative time, but greater intensity and complexity, as the RUC noted that 52352 was an endoscopic outpatient procedure on an otherwise healthy individual and 36222, a percutaneous procedure, was also performed most often as outpatient and 11% in the office and did not carry the risks and intensity of 31603. Finally, the RUC reviewed the relative intra-operative intensity to other recently reviewed codes with similar intensity and agreed that 31603 was relatively as intense and complex. **The RUC recommends a work RVU of 6.00 for CPT code 31603.**

**31605 Tracheostomy, emergency procedure; cricothyroid membrane
Compelling Evidence**

The specialty societies presented compelling evidence that the value for code 31605 was based on a flawed methodology. The specialty societies informed the RUC that Harvard obtained estimates from 10 otolaryngologists only for intraoperative time. General surgeons and other providers of the service were not included in the review. The specialties also indicated that Harvard work estimates and the proposed rule for the 1992 Medicare Physician Payment Schedule indicated code 31605 was a 000-day global code with a proposed work RVU of 5.57 (FR 06/05/91). Prior to implementation of the Final Rule for the first payment schedule, it appears that code 31605 was treated as if it were reviewed as a 090-day global code similar to codes 31601 and 31603 and then reduced to 3.77 as a 000-day global code (FR 11/25/91) without any discussion in the Federal Register text. The RUC accepted the compelling evidence of flawed methodology as presented.

The survey was sent to a random selection of 1,802 surgeons from the AAO-HNS and ACS membership database. Responses were obtained from 56 surgeons; however the median experience was zero. This was not unexpected as this procedure is rarely performed. The survey data was significantly different between respondents who had experience and respondents without experience. After significant discussion, the RUC agreed that the recommendation should be based on the summary data from the experienced providers. The RUC reviewed the survey results from the 20 respondents with experience performing this very low volume service in the past 12 months and agreed that the survey 25th percentile work RVU of 6.45 accurately accounts for the work required to perform this procedure.

The RUC recommends 15 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 20 minutes of intra-service time and 21 minutes of immediate post-operative time. The RUC compared the surveyed code to the top two key reference services 43274 *Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent* (work RVU = 8.58 and intra-service time of 68 minutes) and 32608 *Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU = 6.84 and intra-service time of 60 minutes) and agreed that the intra-service work intensity of 31605 (IWPOT=0.277) is significantly more intense and complex than both of these services. The RUC noted that the intensity of 31605 is more comparable to the intensity for 31500 *Intubation, endotracheal, emergency procedure* (Feb 2016 for CY 2017 RUC recommended work RVU=3.00, intra-service time of 10 minutes and IWPOT=0.252). **The RUC recommends a work RVU of 6.45 for CPT code 31605.**

31610 Tracheostomy, fenestration procedure with skin flaps

The RUC reviewed the survey results from 94 general surgeons and otolaryngologists and recommends the current work RVU of 9.38 and 40 minutes of pre-service evaluation, 10

minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 45 minutes of intra-service time, 20 minutes of immediate post-operative time, 2-99231 subsequent hospital care visits, 1-99232 subsequent hospital care visit, 1-99233 subsequent hospital care visit, 1-99238 discharge day management and 3-99213 office visits. The RUC agreed that the 99232 visit is typically the first inpatient post-operative visit and is more intense and complex than the two 99231 visits because the physician is checking for significant post-op complications such as pneumothorax subcutaneous crepitus and subcutaneous emphysema. The 99231 visits are to evaluate the skin flaps for viability and make sure there is no infection. The 99233 service is typically 4-5 days after the procedure and is the most intense visit because it includes changing the tracheostomy, taking out sutures, removing the tracheostomy, inspecting the area and inserting a new tracheostomy into the stoma. Further, the RUC agreed that 3-99123 office visits are appropriate in order to examine the patient, inspect the larynx, remove the tracheostomy and examine stoma and skin flaps, replace the tracheostomy, cauterize any granulation tissue at stoma, answer patient/family questions, assess for adequacy of pain control and discuss proper maintenance of the tracheostomy including stoma care.

The RUC noted that the previous Harvard physician intra-service time of 61 minutes was computed by an algorithm. The initial Harvard review indicated the intra-operative time was 52 minutes and then finalized at 61 minutes. The RUC noted it is not valid to compare the current surveyed intra-operative time of 45 minutes to the old computed Harvard time. The specialty societies also noted that the Harvard postop visit times were transformed into low level hospital and office visits. The RUC noted that a correction of the postoperative visits to the correct levels results in a negative intensity. **The RUC determined that since this service has a negative IWPUT it should be converted to a 000-day global period and be re-surveyed.**

The RUC compared the surveyed code to the top two key reference services 41120 *Glossectomy; less than one-half tongue* (work RVU = 11.14 and intra-service time of 60 minutes) and 38542 *Dissection, deep jugular node(s)* (work RVU = 7.95 and intra-service time of 60 minutes) and recommends the current value as an interim step as there was no compelling evidence provided to consider a higher value at this time. The intra-operative work for CPT code 31610 is more intense and complex than both 41120 and 38542, both of which are outpatient procedures. The post-operative work for 31610 is significantly greater than both of the key reference services. **The RUC recommends an interim work RVU of 9.38 for CPT code 31610.**

Practice Expense:

CPT codes 31603 and 31605 were identified by the PE Subcommittee as emergent procedures and no practice expense direct inputs were requested for these two services. For CPT code 31610, the RUC recommends the 090-global direct practice expense inputs with minor modifications for additional supplies and equipment that are not standard to Evaluation and Management services.

RUC Database Flag

The RUC recommends to flag CPT codes 31605 and 31610 as “do not use” for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 has a negative IWPUT and should be considered for a 000-day global period.

Global Period

The RUC requests that CMS assign a 000-day global period to CPT code 31610 and it be resurveyed for October 2016 and may require CPT to create a new code to describe changing

the tracheostomy tube in the office. The RUC noted that the specialty does not need to resurvey the entire family.

Work Neutrality

The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Bronchoscopy (Tab 22)

Stephen Hoffmann, MD (ATS); Alan Plummer, MD (ATS); Steve Peters, MD (CHEST); Robert DeMarco, MD (CHEST)

In October 2015, AMA staff re-ran the screen for Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and CPT code 31645 was identified. CPT code 31646 was identified as part of the family.

The specialty societies noted that a Code Change Application (CCA) is needed to describe the services accurately, thereby allowing for an adequate RUC survey. This CCA, attached, will be reviewed by the CPT Editorial Panel in May 2016 and a RUC survey will be conducted for presentation at the October 2016 RUC meeting. **The RUC recommends referral to the CPT Editorial Panel for CPT code 31645 and 31646.**

Selective Catheter Placement (Tab 23)

Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR); Curtis Anderson, MD (SIR); Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Matthew Sideman, MD (SVS); Francesco Aiello, MD (SVS); Timothy Pflederer, MD (RPA)
Facilitation Committee #2

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. *CPT code 36215 also identified via the Harvard Valued – Utilization Over 30,000 screen.* CPT codes 36216, 36217 and 36218 were added as part of the family of services.

36215 Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

The RUC reviewed the survey results from 113 practicing interventional radiologists, vascular surgeons and renal physicians and recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two minutes of positioning time above the standard package to account for positioning the patient supine and orienting the patient, imaging equipment, and lines/catheters to allow for access to the puncture site. Additionally, 5 minutes of scrub, dress, wait time was added above the standard package to maintain a sterile operating room technique when performed in the office suite, requiring scrubbing and sterile gown, mask and gloves for the physician and clinical staff.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey respondents somewhat overvalued the work involved, with a 25th percentile work RVU of 5.25. To find an appropriate work RVU for CPT code 36215, the RUC reviewed CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17, intra time= 30 minutes) and agreed that since this reference code has identical intra-service time compared to 36215 and is an analogous procedure with a similar amount of

physician work, the work RVUs should be identical. To justify a direct physician work RVU crosswalk of 4.17, the RUC also reviewed CPT code 43233 *Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* (work RVU= 4.17, intra-time= 28 minutes) and MPC code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU= 4.05, intra-time= 30 minutes) and agreed that both codes validate the recommended work RVU of 4.17. Finally, the RUC noted the decrease in intra-service time from 61 minutes to 30 minutes. The current time source is Harvard, with all the physicians' time is captured in the intra-service category, without considering the time required for pre and immediate post-service. Comparisons between the prior intensity and current intensity are inappropriate due to the lack of adequate physician time components assigned during the Harvard studies. **The RUC recommends a work RVU of 4.17 for CPT code 36215.**

36216 Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family

The RUC reviewed the survey results from 87 practicing interventional radiologists and vascular surgeons and recommends the following physician time components: pre-service time of 31 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two minutes of positioning time above the standard package to account for positioning the patient supine and orienting the patient, imaging equipment, and lines/catheters to allow for access to the puncture site.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the current work RVU of 5.27, lower than the survey's 25th percentile, is appropriate for CPT code 36216. To justify a work RVU of 5.27, the RUC compared the surveyed code to the top two key reference services CPT code 36246 *Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 5.27, intra time= 45 minutes and code 36223 *Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed* (work RVU= 6.00, intra time= 45 minutes) and agreed that these comparable services provide appropriate comparisons to the recommended value. In addition, the RUC noted the incremental work difference between the work of placing the stent in the first order branch (code 36215) and the initial second order (code 36216) is 1.10 work RVUs with 15 additional minutes. This increment is appropriate and magnitude estimation of this increment is maintained throughout the family of services.

Finally, the RUC noted the decrease in intra-service time from 72 minutes to 45 minutes. The current time source is Harvard, all the physicians' time is captured in the intra-service category, without considering the time required for pre and immediate post-service. Comparisons between the prior intensity are inappropriate due to the lack of adequate physician time components assigned during the Harvard studies. **The RUC recommends a work RVU of 5.27 for CPT code 36216.**

36217 Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family

The RUC reviewed the survey results from 87 practicing interventional radiologists and vascular surgeons and recommends the following physician time components: pre-service time of 31 minutes, intra-service time of 60 minutes and immediate post-service time of 20

minutes. The RUC agreed to add two minutes of positioning time above the standard package to account for positioning the patient supine and orienting the patient, imaging equipment, and lines/catheters to allow for access to the puncture site.

The RUC had significant discussions regarding the appropriate intra-service time for this procedure. The median survey intra-service time was 50 minutes. However, CPT code 36217 includes the work of both 36215 (intra time= 30 minutes) and 36216 (intra time= 45 minutes). Therefore, the median intra-service time of 50 minutes, only 5 minutes above 36216, is not clinically appropriate. The RUC agreed to accept the 75th intra-service time of 60 minutes in order to accurately account for the physician work of placing a catheter in the third order branch. This more accurate intra-service time, preserves the incremental, linear consistency between the work RVU and intra-service time within the family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the current work RVU of 6.29, supported by the survey's 25th percentile work RVU of 6.30, is appropriate for CPT code 36217. To justify a work RVU of 6.29, the RUC compared the surveyed code to the top key reference service CPT code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29, intra time= 60 minutes) and agreed that since both services have identical intra-service time and comparable physician work, the work RVUs should be the same. In addition, the RUC noted the incremental work difference between the work of placing the stent in the second order branch (code 36216) and the initial third order (code 36217) is 1.01 work RVUs with 15 additional minutes. This increment is appropriate and magnitude estimation of this increment is maintained throughout the family of services.

Finally, the RUC noted the decrease in intra-service time from 86 minutes to 60 minutes. The current time source is Harvard, all the physicians' time is captured in the intra-service category, without considering the time required for pre and immediate post-service. Comparisons between the prior intensity are inappropriate due to the lack of adequate physician time components assigned during the Harvard studies. **The RUC recommends a work RVU of 6.29 for CPT code 36217.**

36218 Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family

The RUC reviewed the survey results from 80 practicing interventional radiologists and vascular surgeons and recommends intra-service time of 15 minutes for this add-on procedure.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the current work RVU of 1.01, lower than the survey's 25th percentile, is appropriate for CPT code 36218. To justify a work RVU of 1.01, the RUC compared the surveyed code to MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level* (work RVU= 1.20, intra time= 15 minutes) and code 36148 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention* (work RVU= 1.00, intra time= 15 minutes) and agreed that both reference services have identical intra-service time and should be valued nearly identical to CPT code 36218. Finally, the RUC agreed that the increment of 1.01 for an additional branch with intra-service time of 15 minutes appropriately fits with the incremental hierarchy established with the base codes in this family. **The RUC recommends a work RVU of 1.01 for CPT code 36218.**

Practice Expense:

The RUC approved the direct expense inputs with modifications as approved by the Practice Expense Subcommittee.

Global Period:

The RUC requests that CMS assign CPT codes 36215, 36216 and 36217 a 000-day global period.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Therapeutic Apheresis (Tab 24)

Jonathan Myles, MD (CAP)

CPT code 36516 was identified by Centers for Medicare and Medicaid Services (CMS) as potentially misvalued in the final rule for 2016. At the April 2016 RUC meeting, Therapeutic Apheresis code 36516 was discussed. During the discussion, the Renal Physicians Association and the College of American Pathologists indicated there is a concern that the service is misplaced within the CPT coding structure and this misplacement may have resulted in recent inaccuracy of coding. Specifically, the service is an extracorporeal therapy that is more akin to dialysis services (CPT codes 90935-90999) than to surgical procedures, and the code may need to reside in the 909XX series of codes within the CPT coding structure. The two specialties plan to submit a code change proposal to CPT that will address CPT code 36516 as well as any others in the coding family that may be impacted by a change. The specialty societies will submit a CCP for the September 2016 CPT meeting to address these concerns. **The RUC refers CPT code 36516 to the CPT Editorial Panel.**

Voiding Pressure Studies (Tab 25)

James Dupree, MD (AUA); Thomas Turk, MD (AUA)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. The RUC commented that CPT code 51798 *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging* should be removed from this screen because it has a work RVU of 0.00. In the Final Rule for 2016, CMS indicated that the work and practice expense (PE) for this service should be reviewed.

The PE Subcommittee and the RUC reviewed the direct PE inputs for CPT code 51798. A member questioned one of the supply items *paper, recording, roll (per foot) SK060* and the specialty explained that this is a print out that the machine automatically does and that it is scanned into the electronic medical record. The following modifications were made:

- Removed 1 minute from line 21 *Greet patient, provide gowning, ensure appropriate medical records are available* as it is duplicative of the Evaluation and Management service typically performed on the same day.
- Removed 2 minutes from line 23 *Provide pre-service education/obtain consent* as it is duplicative of the Evaluation and Management service typically performed on the same day.

- Remove 3 minutes from line 43 *Other Clinical Activity - specify: Enter data in EMR* as entering information into the medical record is not typically allocated clinical staff time.
- The unit for supply item *paper, recording, roll (per foot)* SK060 was changed from item to foot.
- The equipment time calculation was modified to include the entire service period for both, the *table, power* EF031 and the *ultrasound, noninvasive bladder scanner w-cart* EQ255.

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Transurethral Electrosurgical Resection of Prostate (Tab 26)

Thomas Turk, MD (AUA); James Dupree, MD (AUA)

Facilitation Committee #3

In October 2015, CPT code 52601 was identified in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period.

52601 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

The RUC reviewed the survey results from 97 urologists for CPT code 52601 and determined that the survey 25th percentile work RVU was too high compared to the key reference services. The RUC recommends cross-walking the survey code to CPT code 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (work RVU = 13.16, intra-service time of 75 minutes and 252 minutes total time) because these services require the same physician work and intra-service time. The RUC recommends 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 75 minutes intra-service time, 45 minutes of immediate post-service time, ½ day discharge management 99238 and two 99213 office visits. The top two key reference services 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56 and intra-service time of 120 minutes) and 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)* (work RVU =13.60 and intra-service time of 100 minutes) require significantly more intra-service time and more physician work. Therefore, the RUC determined the crosswalk to CPT code 29828 was appropriate.

The RUC noted that this service has shifted from the inpatient setting to primarily the outpatient hospital. The RUC confirmed that the immediate post-service time of 45 minutes appropriately accounts for the immediate care of the patient (25 minutes) as well as the post-operative care for the patient within the next 23 hours (20 minutes). As per CMS' policy for 23-hour stay hospital outpatient services, the 20 minutes is derived from the intra-service time of the post-operative hospital visit that is typically performed on the same day. The specialty society noted that approximately 65% of the survey respondents indicated that they performed a 99232 hospital visit and the RUC determined that the time should be captured in the immediate post-service time. The postoperative visit during the 23-hour stay includes conducting the post-operative pain assessment, hand irrigating the catheter, determining the

need for continued catheter traction or continuous bladder irrigation and answering any questions from the patient.

For additional support, the RUC referenced similar service 58545 *Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less*; (work RVU = 12.29, intra-service time of 75 minutes and 226 minutes total time). **The RUC recommends a work RVU of 13.16 for CPT code 52601.**

Practice Expense:

A minor modification to delete 3 minutes for a telephone call on line 49 as it is duplicative of that associated with an Evaluation and Management service was made. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Colporrhaphy (Tab 27)

George A. Hill, MD (ACOG)

In October 2015, CPT code 57240 was identified in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period.

In April 2016, the specialty society indicated they are working with CMS and its contractor NCCI on issues related to the colporrhaphy codes. NCCI instituted edits that prohibit reporting a Cystourethroscopy (CPT code 52000) with these services. The specialty society determined that the most appropriate way to address this issue is through the CPT process. The specialty will submit a CCP for the September 2016 CPT meeting to address these concerns. **The RUC recommends 57240, 57250, 57260 and 57265 be referred to the CPT Editorial Panel.**

Injection Anesthetic Agent (Tab 28)

**Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA); Matthew Grierson, MD (AAPMR); Barry Smith, MD (AAPMR)
Facilitation Committee #1**

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified.

64418 Injection, anesthetic agent; suprascapular nerve

The RUC reviewed the survey results from 139 physicians for CPT code 64418 and determined that the survey median and 25th percentile work RVUs did not adequately account for the work required to perform this service. Therefore, the RUC recommends crosswalking code 64418 to code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10 and 10 minutes intra-service time).

The RUC reviewed the pre-service time for CPT code 66418 and agreed that pre-time package 6A (Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect) is appropriate. However, the RUC did not agree with the specialties recommended pre-time inputs and determined that the pre-time needed to be decreased

further to account for overlap in time with an Evaluation and Management service that typically reported with this service. Therefore, the RUC recommends 6 minutes of evaluation time, 3 minutes of positioning time, 3 minutes of scrub dress and wait time, 10 minutes intra-service time and 10 minutes immediate post-service time. The RUC confirmed that 10 minutes of immediate post-service time is required to assess the patient for pain relief, respiratory, hemodynamic, mental orientation, and extremity vascular status changes; required as a result of the risk of intra-vascular injection or pneumothorax. The physician also assesses any impact on the patient's activities of daily living including eating, bathing, brushing teeth and hair and overhead activities. The physician performs both strength testing and functional assessments to evaluate weakness in the limb that was injected as a result of anesthetic response. The RUC noted that the majority of nerve block codes that were recently reviewed include 10 minutes of immediate post-service time.

The RUC noted that the recommended work RVU of 1.10 and 32 minutes of total time for CPT 66418 is relative compared to the top two key reference services 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75 and 20 minutes total time) and 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU = 1.27 and 35 minutes of total time). The RUC noted that the recommendation is comparable to other nerve block codes 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU = 0.94 and 22 minutes total time) and 64415 *Injection, anesthetic agent; brachial plexus, single* (work RVU = 1.48 and 44 minutes total time). **The RUC recommends a work RVU of 1.10 for CPT code 64418.**

Practice Expense

One minor modification was made to correct the equipment minutes calculation. The Practice Expense Subcommittee reviewed the clinical staff time inputs to ensure that there were no duplicative times with the Evaluation and Management visit. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Correction of Trichiasis (Tab 29)

David Glasser, MD (AAO); Charlie Fitzpatrick, OD (AOA)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

67820 Correction of trichiasis; epilation, by forceps only

The RUC reviewed the survey results from 59 practicing ophthalmologists and optometrists and agreed with the following physician time components: pre-service time of 4 minutes, intra-service time of 5 minutes and immediate post-service time of 2 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate value is below the 25th percentile (work RVU 0.50). The RUC compared the surveyed code to a key reference code 11900 *Injection, intralesional; up to and including 7 lesions* (work RVU= 0.52, intra time= 8 minutes) and noted that it is appropriate to value CPT code 67820 below this comparison given its increased complexity. Additionally the

RUC compared CPT code 11720 *Debridement of nail(s) by any method(s); 1 to 5* (work RVU=0.32 and intra-service time of 5 minutes) noting identical intra-time and physician work. **The RUC recommends a work RVU of 0.32 for CPT code 67820.**

Practice Expense:

The pre-service time was revised to be consistent with the times for minimal use of clinical staff time for a 000 day global service in the facility setting. The RUC approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

X-Ray of Ribs (Tab 30)

Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR)

In October 2015, CPT code 71101 was identified as a CMS/Other source code with 2014 Medicare utilization of 250,000 or more.

Compelling Evidence

The specialty society presented compelling evidence for code 71110. The society noted that a flawed methodology was used in the previous valuation for this service as the code has a CMS/Other designation. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The RUC accepted that there is compelling evidence that 71110 was originally valued using a flawed methodology.

71100 Radiologic examination, ribs, unilateral; 2 views

The RUC reviewed the survey results from 50 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.22 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.22, the RUC compared the survey code to CPT code 73502 *Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views* (work RVU= 0.22, intra-service time of 4 minutes, total time of 6 minutes) and 73521 *Radiologic examination, hips, bilateral, with pelvis when performed; 2 views* (work RVU= 0.22, intra-service time of 4 minutes, total time of 6 minutes). The RUC noted that all three services have identical intra-service and total times and involve similar amounts of physician work. **The RUC recommends a work RVU of 0.22 for CPT code 71100.**

71101 Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views

The RUC reviewed the survey results from 50 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.27 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.27, the RUC compared the survey code to top key reference code 73503 *Radiologic examination,*

hip, unilateral, with pelvis when performed; minimum of 4 views (work RVU= 0.27, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services have identical intra-service and total times and involve a similar amount of physician work. The RUC also reviewed CPT code 72050 *Radiologic examination, spine, cervical; 4 or 5 views* (work RVU= 0.31, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service time and involve a similar physician work intensity, confirming that a work RVU of 0.27 is appropriate for the survey code. **The RUC recommends a work RVU of 0.27 for CPT code 71101.**

71110 Radiologic examination, ribs, bilateral; 3 views

The RUC reviewed the survey results from 50 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 6 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.29 and agreed that this value appropriately accounts for the physician work involved and aligns appropriately with the other codes in the x-ray of ribs code family. To justify a work RVU of 0.29, the RUC compared the survey code to 2nd key reference code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 views* (work RVU= 0.31, intra-service time of 5 minutes, total time of 8 minutes) and noted that while both services have identical total times, the survey code has more intra-service time. The RUC also compared the survey code to CPT code 73523 *Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views* (work RVU= 0.31, intra-service time of 6 minutes, total time of 8 minutes) and noted that both services have identical times and involve a similar amount of physician work, supporting a work RVU of 0.29 for the survey code. **The RUC recommends a work RVU of 0.29 for CPT code 71110.**

71111 Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views

The RUC reviewed the survey results from 50 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 7 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU and agreed that maintaining the current work RVU of 0.32 is supported. To justify a work RVU of 0.32, the RUC compared the survey code to 2nd key reference and MPC code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, intra-service time of 5 minutes, total time of 8 minutes) and noted that the survey code has more intra-service and total time. The RUC also compared the survey code to CPT code 72083 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 4 or 5 views* (work RVU= 0.35, intra-service time of 7 minutes, total time of 9 minutes) and noted that although both codes have identical times, the survey code involves somewhat less intense physician work, supporting a somewhat lower work RVU of 0.32 for the survey code. **The RUC recommends a work RVU of 0.32 for CPT code 71111.**

Practice Expense

The RUC recommends the direct practice expense inputs as submitted by the specialty and reviewed and approved by the Practice Expense Subcommittee.

CT Chest (Tab 31)

Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

Compelling Evidence

The specialty society presented compelling evidence for code 71250. The society noted that a flawed methodology was used in the previous valuation for this service as instead of accepting the RUC recommended value of 1.16, CMS assigned a work RVU of 1.02 based on the single lowest response to the survey. The RUC agreed that using a work RVU based on the survey minimum RVU is statistically invalid and inappropriate. The RUC accepted that there is compelling evidence that 71250 was originally valued using a flawed methodology.

71250 Computed tomography, thorax; without contrast material

The RUC reviewed the survey results from 76 radiologists and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 15 minutes and post-service time of 5 minutes.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.19, and agreed that reaffirming the October 2009 RUC recommended work RVU of 1.16 is supported by the new survey data. The RUC also noted that this value has appropriate rank order relative to the other codes in the family. The RUC compared the survey code to MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.27, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times, whereas the survey is somewhat less intense. The RUC also compared the survey code to CPT code 78071 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)* (work RVU= 1.20, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times and involve similar amounts of physician work.

As the RUC agreed that its prior recommendation for 71250 was still appropriately relative, the RUC re-affirmed the recommendations made for this code at the October 2009 RUC meeting:

The RUC reviewed survey data from nearly 60 physicians who frequently perform this service. The specialty recommended a pre-service time of 5 minutes based on the survey results and the RUC concurred. The RUC also agreed that the surveyed intra-service of 15 minutes and immediate post service time of 5 minutes were typical for the physician work required for the service. The total time of 25 minutes is comparable to the 22 minutes of total time assumed by CMS.

The RUC compared 71250 to key reference service 71260 *Computed tomography, thorax; with contrast material(s)* (work RVU = 1.24, with pre, intra, and post service times of 3, 15, and 5 minutes respectively), and noted that the survey respondents indicated that in general a CT of the thorax without contrast is a slightly less intense service than one with contrast, as reflected in slightly lower values for the intensity and complexity measures. The RUC also compared 71250 to the specialty's multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body*

(work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 minutes respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 minutes respectively).

The RUC agreed that there is significant evidence to support the current valuation, given changes in technology and the patient population. The RUC and the specialty cited the following as evidence to maintain the work relative value of 1.16 for CT of the thorax:

- Modern CT technology produces an increased amount of data to be reviewed and interpreted. Because of the improved spatial resolution and multi-planar reformation of the data, a higher level of diagnostic specificity and accuracy is expected, and the number of possible protocols to be considered in the pre-service period by the interpreting physician has increased. Many patients require prone and supine imaging with both inspiration and expiration for the evaluation of interstitial lung disease. Further, 2D reconstructions (previously separately billable using code 76375 *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality* in 2005 with 0.16 work RVUs) were bundled into the base code in 2006 and are now being considered an inherent part of the service.
- Using multi-detector row CT scanners, modern high resolution CT protocols are able to generate contiguous 1.25 mm images through the entirety of the lungs which are also used to create coronal 2D reconstructions to more accurately assess distribution of disease. As such, these examinations now generate more than 300 images for interpretation.
- The expectation of the referring physician is now much higher in terms of defining the various subtypes of interstitial lung disease and also in evaluating whether a lung nodule merits follow up or more aggressive intervention. The incidence of smoking-related lung disease continues to increase in the Medicare population, as does the ability to characterize these diseases with the advent of high resolution multi-detector CT. Current estimates are that pulmonary emphysema and the smoking related interstitial lung diseases – centrilobular emphysema, respiratory bronchiolitis interstitial lung disease (RBILD), desquamative interstitial pneumonia (DIP), and Langerhan’s cell histiocytosis (LCH) – are among the top ten causes of morbidity and mortality in the Medicare population and both morbidity and mortality from these illnesses are expected to increase by 2020.
- Because of refinements in technique and the ability to examine the entire lung, specific diagnoses of potentially reversible diseases such as RBILD and DIP can now be made and differentiated from irreversible diseases such as LCH and pulmonary fibrosis (usual interstitial pneumonia) without open lung biopsy or the need to institute potentially harmful empiric therapy without a definitive diagnosis. The extent and distribution of pulmonary centrilobular and bullous emphysema is now well characterized and critically important in both medical and surgical treatment planning.

While CT technology is changing rapidly, the adoption of newer techniques is not yet universal. The reasons for the increase in utilization of non-enhanced CT procedures are likely multi-factorial but concerns over the use of intravenous contrast and its potential nephrotoxicity in at-risk patients is felt to contribute at least in part to this increase.

Advances in CT technology have provided new indications for non-enhanced CT leading to volume growth. The most common indication for non-enhanced CT of the thorax is evaluation and follow-up of pulmonary nodules. The ability to detect small non-calcified pulmonary nodules has increased dramatically in recent years with high-resolution exam protocols. And while any of these nodules could represent small malignancies, most of the nodules are benign. The protocol for following likely benign pulmonary nodules developed by the Fleischner Society stated that pulmonary nodules should be followed with serial CT examinations for two years to assure benignity. Recent literature has prompted a re-evaluation of these guidelines by the Fleischner Society with the end result being a statement that will drastically reduce the number of follow-up examinations in low-risk patients with nodules less than 8 mm in size. These recommendations are supported by pulmonary medicine and thoracic surgery societies as well, and it is expected that the volume of these service will likely decrease in the future as these practice guidelines are established in the community.

From the survey results, comparison of similar services, rank order maintenance, and considerations regarding the rationale for the volume growth in the service, the RUC agreed that the physician work relative value should be maintained at its current value of 1.16 work RVUs, which was lower than the survey's 25% percentile of 1.20. The RUC acknowledges the growth in CT scans in the Medicare population. However, there is no evidence that this growth has led to a reduction in physician resources, as confirmed by the recent survey time data.

The RUC recommends maintaining the relative work value for CPT code 71250 of 1.16.

The RUC recommends a work RVU of 1.16 for CPT code 71250.

71260 Computed tomography, thorax; with contrast material(s)

The RUC reviewed the survey results from 76 radiologists and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 16 minutes and post-service time of 5 minutes.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.27, and agreed that maintaining the current work RVU of 1.24 is supported by the new survey data. The RUC compared the survey code to MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35, intra-service time of 20 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times and involve similar physician work. **The RUC recommends a work RVU of 1.24 for CPT code 71250.**

71270 Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections

The RUC reviewed the survey results from 76 radiologists and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 5 minutes.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.40, and agreed that maintaining the current work RVU of 1.38 is supported by the new survey data. The RUC compared the survey code to MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35, intra-service time of 20 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times and while the survey code involves somewhat more physician work. The RUC also compared the survey code to MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.40, intra-service time of 18 minutes, total time of 28 minutes, and noted that the survey code has slightly more intra-service and total times, supporting a work RVU of 1.38 for the survey code. **The RUC recommends a work RVU of 1.38 for CPT code 71270.**

Practice Expense

A detailed discussion was convened regarding specialty society's recommendation to include 3 minutes for the CT Technologist (L046A) to *Technologist QC's images in PACS, checking for all images, reformats, and dose page* (line 44). Often this clinical labor input requires 2 minutes of clinical staff time; however this line item does not have a standard time. An additional minute above the typical is warranted for these CT Chest codes. During the discussion, precedent was cited from the practice expense review for Mammography services and Cardiac MR services.

The RUC recommends the direct practice expense inputs as submitted by the specialty and reviewed and approved by the Practice Expense Subcommittee.

X-Ray of Wrist (Tab 32)

Zeke Silva III, MD (ACR); Kurt A. Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Anne Miller, MD (ASSH); William Creevy, MD (AAOS); John Heiner, MD (AAOS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. Code 73110 was identified in this screen and code 73100 was added as a family code.

73100 Radiologic examination, wrist; 2 views

The RUC reviewed the survey results from 97 radiologists, hand surgeons and orthopaedic surgeons and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.16 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.16, the RUC compared the survey code to the primary key reference code 73600 *Radiologic examination, ankle; 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that both services have identical intra-service and total times and involve a similar amount of physician work. The RUC also compared the survey code to the

second key reference code 73060 *Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that both services have identical physician times and involve a similar amount of physician work. **The RUC recommends a work RVU of 0.16 for CPT code 73100.**

73110 *Radiologic examination, wrist; complete, minimum of 3 views*

The RUC reviewed the survey results from 97 radiologists, hand surgeons and orthopaedic surgeons and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.17 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.17, the RUC compared the survey code to MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that the survey code has more intra-service time and identical total time. The RUC also compared the survey code to the primary key reference code 73080 *Radiologic examination, elbow; complete, minimum of 3 views* (work RVU= 0.17, intra-service time of 3 minutes, total time of 5 minutes) and noted that the survey code has more intra-service and total time. **The RUC recommends a work RVU of 0.17 for CPT code 73110.**

Practice Expense

The specialty met compelling evidence that there is a change from previous code-specific practice expense to adoption of a newly applicable standard or package. The amount of time for acquiring images was increased to 8 minutes for 73110, because the CPT descriptor has a minimum of 3 views and in the typical scenario 4 views are performed. The change to 8 minutes would insure that the typical number of views for this service would follow a logical progression per view. PACS workstations are also typically present in the office-based practices of orthopaedic surgeons and hand surgeons, so the inclusion of a PACS workstation is warranted. The RUC determined that the inclusion of SB026 gown is not typical for codes 73100 or 73110 and therefore removed that supply input. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

X-Ray of Hands and Fingers (Tab 33)

Zeke Silva, III, MD (ACR); Kurt A. Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Anne Miller, MD (ASSH); William Creevy, MD (AAOS); John Heiner, MD (AAOS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. Code 73130 was identified in this screen and codes 73120 and 73140 were added as family codes.

73120 *Radiologic examination, hand; 2 views*

The RUC reviewed the survey results from 93 radiologists, hand surgeons and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

The RUC reviewed the 2014 Medicare claims data for this service and confirmed that diagnostic radiology is the dominant provider for global reporting and 26-modifier reporting in aggregate.

The RUC reviewed the survey 25th percentile work RVU of 0.16 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.16, the RUC compared the survey code to the primary key reference code 73600 *Radiologic examination, ankle; 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and the second key reference code 73060 *Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that the survey code includes more intra-service time and total time relative to the reference codes. **The RUC recommends a work RVU of 0.16 for CPT code 73120.**

73130 Radiologic examination, hand; minimum of 3 views

The RUC reviewed the survey results from 93 radiologists, hand surgeons and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU of 0.17 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.17, the RUC compared the survey code to MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that the survey code has more intra-service time and total time. The RUC also compared the survey code to the second key reference code 73080 *Radiologic examination, elbow; complete, minimum of 3 views* (work RVU= 0.17, intra-service time of 3 minutes, total time of 5 minutes) and noted that the survey code has more intra-service and total time. **The RUC recommends a work RVU of 0.17 for CPT code 73130.**

73140 Radiologic examination, finger(s), minimum of 2 views

The specialty societies presented compelling evidence that hand surgeons were not involved the previous review of this code in 2005 and that the work and times recorded were based on flawed data. The RUC rejected compelling evidence, indicating that hand surgeons are not the dominant providers and a hand surgeon was involved in the presentation to the RUC in 2005.

The RUC reviewed the survey results from 93 radiologists, hand surgeons and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

The RUC reviewed the survey data and agreed that since compelling evidence was not accepted, the existing value of 0.13 should be maintained for this service. The RUC compared the survey code to the top key reference code 73060 *Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and the second key reference code 73600 *Radiologic examination, ankle; 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that the survey code includes more intra-service time and total time relative to the reference codes. The RUC also noted that all RUC reviewed plain film codes with one or two views were valued at 0.16, however since compelling evidence was not accepted, an increased work RVU for 73140 was not appropriate. **The RUC recommends a work RVU of 0.13 for CPT code 73140.**

Practice Expense

The specialty met compelling evidence that there is a change from previous code-specific practice expense to adoption of a newly applicable standard or package. The RUC determined that the inclusion of SB026 gown is not typical for codes 73120, 73130 or 73140 and

therefore removed that supply input. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CT Angiography of Abdominal Arteries (Tab 34)
Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

75635 Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including-noncontrast images, if performed, and image postprocessing

The RUC reviewed the survey results from 65 radiologists and agreed with the following physician time components: pre-service time of 10 minutes, intra-service time of 39 minutes and post-service time of 8 minutes. The RUC noted that, although there was a modest decrease in physician time relative to when this service was last reviewed by the RUC in 2001, the number of images has increased several fold and the detail in those image reconstructions has increased. The RUC agreed that the change in the amount and detail of these images would make the work somewhat more intense to perform.

The specialty society noted that the survey code was presented separately from other CTA codes as this service represents a different patient populations and different diagnoses. For example, the typical patient receiving a CTA of abdominal arteries has peripheral vascular disease, as opposed to CTA Abdomen and Pelvis where aortic disease or visceral disease are typical. The RUC agreed the survey code does not have any other services within the same family.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 2.45, which is somewhat higher than the existing work RVU, and agreed that the survey data supports maintaining a work RVU of 2.40 for the code. The RUC compared the survey code to key reference code 74262 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed* (work RVU= 2.50, intra-service time of 45 minutes, total time of 57 minutes) and noted that both services have identical total times, while the survey code involves somewhat more intense work, supporting a work RVU of 2.40 for the survey code. To further justify a work RVU of 2.40, the RUC compared the survey code to MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU= 2.50, intra-service time of 36.5 minutes, total time of 66.5 minutes) and noted that the survey code has more intra-service time and involves somewhat more intense physician work. The RUC also compared the survey code to other CT Angiography services such as, 73706 *CT Angiography, lower extremity, with contrast, including noncontrast images, if performed, and post processing* (work RVU= 1.90) and 74174 *CT Angiography, abdomen and pelvis, with contrast, including noncontrast images, if performed, and post processing* (work RVU= 2.20) and agreed that the valuation of the survey code is appropriate relative to these other CTA services. **The RUC recommends a work RVU of 2.40 for CPT code 75635.**

Practice Expense

The clinical staff time inputs were revised to ensure that there is sufficient time for the clinical staff to obtain consent and to prepare the supplies to accommodate the angiography. Additionally, the equipment minutes were corrected for the CT room as it is used to acquire the images, but not during the post processing. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Ophthalmic Ultrasound (Tab 35)

David B. Glasser, MD (AAO)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 76512 was identified via this screen and codes 76510 and 76511 were added for review as part of this family of services.

The specialty societies indicated a scheduling conflict for the American Society of Retina Specialists (ASRS) to be able to survey for the April 2016 RUC meeting. The RUC inquired about the delay and learned that ASRS had a meeting conflict which would have prohibited their involvement in the survey process. The RUC agreed that it was important for the appropriate specialties to be involved and that the delay would not impact the ability of the RUC to value the codes within the current cycle. Therefore, the RUC agreed that a delay in surveying for the October RUC meeting would be appropriate. **The RUC recommends delay to the October 2016 RUC meeting for CPT codes 76510, 76511, and 76512.**

Ophthalmic Biometry (Tab 36)

David B. Glasser, MD (AAO)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

76516 Ophthalmic biometry by ultrasound echography, A-scan;

The RUC reviewed the survey results from 86 practicing ophthalmologists and agreed with the following time components: pre-service time of 2 minutes, intra-service time of 10 minutes and immediate post-service time of 2 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate value is the 25th percentile (work RVU= 0.40). The RUC compared the surveyed code to top key reference code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg; or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU= 0.50, intra time= 10 minutes) and noted that both services have identical intra-service time and comparable physician work. The RUC also compared to CPT code 92541 *Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording* (workRVU=0.40, intra time=10 minutes) as a recently reviewed (RUC review 2014) code with identical intra-service time. **The RUC recommends a work RVU of 0.40 for CPT code 76516.**

76519 Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation

The RUC reviewed the survey results from 99 practicing ophthalmologists and agreed with the following time components: pre-service time of 2 minutes, intra-service time of 10 minutes and immediate post-service time of 10 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate value is between the median value (work RVU= 0.70) and 25th percentile (work RVU= 0.51), which aligns with maintaining the current work RVU of 0.54. The RUC compared the surveyed code to top key reference code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg.;, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU= 0.50, intra time= 10 minutes) and noted that both services have identical intra-service time and comparable physician work. **The RUC recommends a work RVU of 0.54 for CPT code 76519.**

92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation

The RUC reviewed the survey results from 101 practicing ophthalmologists and agreed with the following time components: pre-service time of 2 minutes, intra-service time of 10 minutes and immediate post-service time of 10 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate value is between the median value (work RVU= 0.75) and 25th percentile (work RVU= 0.50), which aligns with maintaining the current work RVU of 0.54. The RUC compared the surveyed code to top key reference code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg.;, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU= 0.50, intra time= 10 minutes) and noted that both services have identical intra-service time and comparable physician work. **The RUC recommends a work RVU of 0.54 for CPT code 92136.**

Practice Expense:

The RUC approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Radiation Therapy Planning (Tab 37)

Michael Kuettel, MD, PhD (ASTRO); Peter Orio III, DO (ASTRO)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code

77263 was identified by this criteria and CPT code 77261 and 77262 were added as part of the family of services.

77261 Therapeutic radiology treatment planning; simple

The RUC reviewed the survey results from 143 practicing radiation oncologists and recommend the following physician time components: pre-service time of 3 minutes, intra-service time of 30 minutes and immediate post-service time of 3 minutes.

The RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the survey's 25th percentile work RVU of 1.30, lower than the current work RVU of 1.39, is appropriate. To justify a work RVU of 1.30, the RUC compared the surveyed code to the top key reference service CPT code 77306 *Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)* (work RVU= 1.40, intra time= 30 minutes) and agreed that while the two services have comparable physician work, the reference code has more intra-service time and should be valued higher. The RUC also reviewed CPT codes 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU= 1.24, intra time= 35 minutes) and 77768 *Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions* (work RVU= 1.40, intra time= 35 minutes) and agreed both services offer reasonable comparisons to the recommended value.

Finally, the RUC discussed the current CMS/Other physician time. This service was originally assigned a work value and times by CMS over 20 years ago using some unknown methodology, making it inappropriate to compare changes in total time. In addition to the existing times having been assigned using a flawed methodology, the RUC noted that only existing total time was assigned, making it not possible to compare changes in intra-service time. Accounting for appropriate time allocation, the intensity has not meaningfully changed. **The RUC recommends a work RVU of 1.30 for CPT code 77261.**

77262 Therapeutic radiology treatment planning; intermediate

The RUC reviewed the survey results from 144 practicing radiation oncologists and recommend the following physician time components: pre-service time of 3 minutes, intra-service time of 45 minutes and immediate post-service time of 6 minutes.

The RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the survey's 25th percentile work RVU of 2.00, lower than the current work RVU of 2.11, is appropriate. To justify a work RVU of 2.00, the RUC compared the surveyed code to the top two key reference services CPT codes 77317 *Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)* (work RVU= 1.83, intra time= 50 minutes) and 77307 *Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)* (work RVU= 2.90, intra time= 80 minutes) and agreed that both these reference codes provide appropriate brackets around the recommended value. The RUC also reviewed CPT code 77770 *Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel* (work RVU= 1.95, intra time= 45 minutes) and agreed that both services have comparable physician time and work and should be valued similarly.

Finally, the RUC discussed the current CMS/Other physician time. This service was originally assigned a work value and times by CMS over 20 years ago using some unknown methodology, making it inappropriate to compare changes in total time. In addition to the existing times having been assigned using a flawed methodology, the RUC noted that only existing total time was assigned, making it not possible to compare changes in intra-service time. Accounting for appropriate time allocation, the intensity has not meaningfully changed. **The RUC recommends a work RVU of 2.00 for CPT code 77262.**

77263 Therapeutic radiology treatment planning; complex

The RUC reviewed the survey results from 146 practicing radiation oncologists and recommend the following physician time components: pre-service time of 7 minutes, intra-service time of 60 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the current work RVU of 3.14, lower than the survey's 25th percentile value, is appropriate. To justify a work RVU of 3.14, the RUC compared the surveyed code to the second key reference service 77307 *Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)* (work RVU= 2.90, intra time= 80 minutes) and agreed that while both services have analogous physician work, with similar total time, surveyed code is more intense procedure and is correctly valued higher. In addition, the RUC reviewed several recently RUC reviewed services with identical intra-service time to validate the recommended work value across a broad spectrum of services: CPT code 38241 *Hematopoietic progenitor cell (HPC); autologous transplantation* (work RVU= 3.00), 90792 *Psychiatric diagnostic evaluation with medical services* (work RVU= 3.25) and 94012 *Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age* (work RVU= 3.10).

Finally, the RUC discussed whether it is possible to compare changes in intra-service time. Unlike the other codes in this family, this service was RUC reviewed in 2005. However, the survey only collected total time and thus does not have appropriate breakouts for pre- and post-service time. Accounting for appropriate time allocation, the intensity has not meaningfully changed. **The RUC recommends a work RVU of 3.14 for CPT code 77263.**

Practice Expense:

There are no direct practice expense inputs for these services. These services represent physician work only.

Work Neutrality

The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Bone Imaging (Tab 38)

Gary Dillehay, MD (SNMMI); Scott Bartley, MD (ACNM); Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 78306 was identified via this screen.

During the RUC's discussion of this tab, the specialty societies noted and the RUC agreed that physician work governed by regulatory requirements happens both in the pre-service and post-service periods. The specialty societies noted that before the study is performed, the physician must review flood sources and perform tasks pertaining to receipt of the radiopharmaceutical; after the intra-service period, there are regulatory review tasks pertaining to review of surveys and disposal or return of radiopharmaceuticals.

78300 Bone and/or joint imaging; limited area

The RUC reviewed the survey results from 137 physicians and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes. The RUC noted that the Harvard Study only measured total time for this service, so a comparison of change in intra-service time is not possible.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.70, and agreed that maintaining the current work RVU of 0.62 is appropriate. To further validate a work RVU of 0.62, the RUC compared the survey code to top key reference code 78226 *Hepatobiliary system imaging, including gallbladder when present*; (work RVU= 0.74, intra-service time of 10 minutes, and total time of 20 minutes) and noted that both services have identical intra-service and total times and the survey respondents rated both services as involving a similar amount of intensity and complexity. The RUC also compared the survey code to CPT code 76856 *Ultrasound, pelvic (nonobstetric), real time with image documentation; complete* (work RVU= 0.69, intra-service time of 10 minutes, total time of 20 minutes) and noted that both services have identical intra-service and total times and involve a similar amount of physician work. **The RUC recommends a work RVU of 0.62 for CPT code 78300.**

78305 Bone and/or joint imaging; multiple areas

The RUC reviewed the survey results from 132 physicians and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes.

The RUC noted that although the survey times were identical relative to 78300, the amount of physician work of bone imaging studies for multiple areas represents more physician work relative to only a limited area. The RUC also noted that although the Harvard Study only measured total time for this service, so a comparison of change in intra-service time is not possible.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.85, and agreed that maintaining the current work RVU of 0.83 is appropriate. To further validate a work RVU of 0.83, the RUC compared the survey code to 70486 *Computed tomography, maxillofacial area; without contrast material* (work RVU= 0.85, intra-service time of 10 minutes, total time of 16 minutes) and noted that both services have identical intra-service time, while the survey code includes more total time. The RUC also compared the survey code to CPT code 78453 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU= 1.00, intra-service time of 10 minutes, total time of 20 minutes) and noted that identical intra-service time and total times, a work RVU of 0.83 for the survey code is supported. **The RUC recommends a work RVU of 0.83 for CPT code 78305.**

78306 Bone and/or joint imaging; whole body

The RUC reviewed the survey results from 143 physicians and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes.

The RUC noted that although the survey times were identical relative to 78306, the amount of physician work of bone imaging studies for the whole body represents more work relative to only multiple areas.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.90, and agreed that maintaining the current work RVU of 0.86 is appropriate. To further validate a work RVU of 0.86, the RUC compared the survey code to the RUC compared the survey code to 70486 *Computed tomography, maxillofacial area; without contrast material* (work RVU= 0.85, intra-service time of 10 minutes, total time of 16 minutes) and noted that both services have identical intra-service time, while the survey code includes more total time. The RUC also compared the survey code to CPT code 78453 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU= 1.00, intra-service time of 10 minutes, total time of 20 minutes) and noted that identical intra-service time and total times, a work RVU of 0.86 for the survey code is supported. **The RUC recommends a work RVU of 0.86 for CPT code 78306.**

Practice Expense

It was determined that the clinical staff perform surveys of areas used during imaging and documentation for regulatory compliance during the clinical labor post-service period after the patient has left the office and not during the post-service portion of the service period when the patient is still in the office. Making this reallocation also reduced the PACS Workstation equipment time by 3 minutes for each code. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Pathology Consultation During Surgery (Tab 39)

Jonathan Myles, MD (CAP); Swati Mehrotra, MD (ASC)

Following publication of the 2014 Final Rule, the RUC solicited feedback from the specialties societies regarding CPT codes potentially impacted by the OPPI/ASC Payment Cap. Specialty societies indicated an interest in re-reviewing or validating a recent RUC review for PE only, for 58 of the 211 codes identified through the cap. The PE Subcommittee reviewed the codes identified by specialty societies, grouped by families, at the April 2014 RUC meeting and provide CMS with the recommendations as a sample subset of the codes impacted by the cap. CPT codes 88333 and 88334 were included in these recommendations. CMS chose not to implement the RUC recommendations for 2015, but has reviewed and accepted the recommendations with refinement for 2016. CMS expressed concern about the way the services were selected for review and limiting the review to PE only. The RUC understand CMS' concerns about implementing PE inputs without the corresponding work being reviewed. AMA staff analyzed the 58 services that the RUC submitted PE recommendations for and determined that one or more of the following is true of most of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. The application of this criteria, results in only 6 remaining codes. The codes are 10021, 30903, 88333, 88334, 95812 and 95813.

88333 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site

The RUC reviewed the survey results from 53 pathologists and cytopathologists and determined that it was appropriate to maintain the current work RVU of 1.20, which is supported by the survey median of 1.20. The RUC recommends 25 minutes intra-service time. The RUC compared the surveyed code to the top key reference service 88331, *Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen* (work RVU = 1.19, intra-service time of 25 minutes) and noted that both services have similar physician work and should be valued similarly. For additional support the RUC compared the surveyed code to CPT code 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU = 1.20, intra-service time of 30 minutes) and noted that the surveyed code requires slightly less intra-service time, but is more intense to perform justifying the identical work RVUs. **The RUC recommends a work RVU of 1.20 for CPT code 88333.**

88334 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 41 pathologists and cytopathologists and determined that it was appropriate to maintain the current work RVU of 0.73, which is supported by the survey 25th percentile of 0.75. The RUC recommends 20 minutes intra-service time. The RUC compared the surveyed code to the top key reference service 88332, *Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)* (work RVU = 0.59, intra-service time of 16 minutes) and noted that the surveyed code as greater intra-service time and is appropriately valued higher. For additional support the RUC compared the surveyed code to CPT code 95887 *Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)* (work RVU = 0.71, intra-service time of 20 minutes) and noted that the both services have identical intra-service time and similar intensity and should be valued similarly. Additionally the RUC discussed that 88334 is an add-on code and should have a ZZZ global period rather than a XXX global period. **The RUC recommends a work RVU of 0.73 for CPT code 88334.**

Global Period

The RUC requests that CMS assign a ZZZ global period to CPT code 88334. The RUC noted that the Committee's other recommendations are not contingent on this global period change, as this code does not include any pre-service or post-service time.

Practice Expense

The RUC recommends the direct practice expense inputs as submitted by the specialty societies and approved by the Practice Expense Subcommittee.

Tumor Immunohistochemistry (Tab 40)

**Jonathan Myles, MD (CAP); Swati Mehrotra, MD (ASC);
Roger McLendon, MD (CAP)**

In the Proposed Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes

88360 and 88361 were among the codes under this high expenditure screen for which CMS sought recommended values from the RUC and other interested stakeholders,

88360 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual

The RUC reviewed the survey results from 60 practicing pathologists and cytopathologists and recommends 23 minutes of intra-service time. The RUC then reviewed the survey respondents' estimated physician work values and noted that the survey's 25th percentile work RVU of 0.85, lower than the current work RVU of 1.10, is appropriate for this code. To justify a work value of 0.85, the RUC compared the surveyed code to the top key reference code 88342 *Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure* (work RVU= 0.70, intra time= 25 minutes) and agreed that code 88360 is a more intense procedure than code 88342; although it has slightly less intra-service time, it should be valued higher. With code 88342, the physician is only giving a positive or negative result. Whereas in code 88360 the physician must, in addition to reporting the result, also give a quantitative or semi-quantitative analysis of the number of positive cells.

To corroborate this assertion, the RUC, noting the drop in intra-service time and the change in intensity since the previous valuation, had a significant discussion regarding the rise in intensity due to a lower survey time. In 2010, practice guidelines were published by the American Society of Clinical Oncology and the College of American Pathologists regarding the reporting of estrogen and progesterone receptor results. Prior to the guidelines, there was no consensus as to what constituted a positive result. Now physicians are now required to do the following: report a percentage of positive cells, indicate whether the staining is weak, moderate or strong, check the length and type of fixation and document the status of internal and external control tissue. All of this was not required when the code was last reviewed in 2004. Given this robust set of clinical information, the RUC confirmed that the intensity has increased and the recommended value is appropriately higher than the top key reference service. **The RUC recommends a work RVU of 0.85 for CPT code 88360.**

88361 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology

The RUC reviewed the survey results from 53 practicing pathologists and cytopathologists and recommends 25 minutes of intra-service time. The RUC then reviewed the survey respondents' estimated physician work values and noted that the survey's 25th percentile work RVU of 0.95, lower than the current work RVU of 1.18, is appropriate for this code. To justify a work value of 0.95, the RUC compared the surveyed code to the top two key reference codes 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU= 1.00, intra time= 25 minutes) and 88342 *Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure* (work RVU= 0.70, intra time= 25 minutes) and agreed that the work involved in code 88361 is more analogous to code 88121 than code 88342. The surveyed code and code 88121 both contain similar physician work in that both use computer-assisted technology and include morphometry. The second key reference code contains neither element. Additionally, the top key reference code and the surveyed code are also more intense procedures because the findings result in direct therapeutic intervention.

In addition to discussing the issue of increased intensity for this service due to the lower survey time, which is covered in the discussion above for code 88360, the RUC also noted

that the physician work is greater for code 88361 compared to 88360, even though computer-assisted technology is involved. With the aid of the computer, the physician is able to review many more cells compared to the manual approach. Furthermore, the computer does not just produce the answers. The physician must still check the staining intensity, review fixation and ensure the technologist set the gait correctly in order to identify the correct target area. Given this information, the RUC agreed that the recommend value is appropriate relative to both the top key reference service and the other manual procedure (88360) in the family. **The RUC recommends a work RVU of 0.95 for CPT code 88361.**

Practice Expense:

The RUC approved the direct practice expense inputs with the specialty society's modifications as approved by the Practice Expense Subcommittee.

Work Neutrality

The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Glaucoma Provocative Tests (Tab 41)

David B. Glasser, MD (AAO)

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified.

The specialty societies noted that they believe the increase usage is due to incorrect coding and have submitted a Coding Change Application to the CPT Editorial Panel. The RUC noted that the review of this code for potential deletion will occur at the May 2016 CPT meeting. **The RUC recommends referral of CPT code 92140 to the CPT for deletion.**

Transthoracic Echocardiography (TTE) (Tab 42)

Richard Wright, MD (ACC); Thad Waites, MD (ACC); Michael Main, MD (ASE)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 93306 was identified by CMS.

Compelling Evidence

The specialty societies indicated that there has been a change in technique and diffusion of technology used to perform 93306. The digital evolution and more sophisticated computers allow for additional modalities to be deployed for echocardiography. The eleven different windows for each echocardiography now comprise more information per study. The physician also performs new services such as diastolic function and spectral tracking, resulting in more images. The physician now reviews 84 video loops for a typical study. Additionally, there have been many accreditation body requirements since this service was last valued, which increases the work per study. For example, the American Society of Echocardiography has published 27 different guideline/clinical recommendations. The RUC accepts compelling evidence that the work for CPT code 93306 has changed.

93306 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

The RUC reviewed the survey results from 172 cardiologists for CPT code 93306 and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes of pre-service evaluation time, 20 minutes of intra-service time and 5 minutes of post-service time. The RUC agreed that the intensity for this service has increased in the last 10 years because the physician reviews more images in the same amount of time and performs additional testing such as diastolic function and spectral tracking. Part of the standard of care now includes the physician calculation of left ventricular ejection fraction in many patient populations. This is all incremental physician work that is not an automated function. The RUC agreed that there may be minor efficiencies in time for this service; however the intensity in work has been compounded by the increase in technology and the number of images to review, additional testing and calculations that the physician is now conducting.

The RUC compared 93306 to top key reference service 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.62 and 20 minutes intra-service time). The survey respondents indicated that 93306 is somewhat more intense/complex than 78452, however the intra-service times are identical (20 minutes). The specialty societies indicated that the higher intensity and complexity measures, likely reflect the more diverse disease processes to consider when the physician is reviewing the images. CPT code 93306 provides a non-invasive comprehensive assessment of cardiac structure and function which includes measurements performed in the course of the examination, 2-dimensional and/or M-Mode numerical data for transthoracic echocardiograms, and Doppler/color flow data. Whereas, CPT code 78452 assesses heart conditions including myocardial wall motion abnormalities with myocardial perfusion at stress and rest. The total time differences between codes 78452 and 93306 were solely based on the shorter pre- and post-service time periods, which are balanced by the difference in work RVUs.

For additional support, the RUC referenced MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74 and 22 minutes intra-service) and similar service 72146 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material* (work RVU = 1.48 and 20 minutes intra-service time). **The RUC recommends a work RVU of 1.50 for CPT code 93306.**

93307 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography

The RUC reviewed the survey results from 152 cardiologists for CPT code 93307 and determined that the current work RVU of 0.92, lower than the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes of pre-service evaluation time, 15 minutes of intra-service time and 5 minutes of post-service time. The RUC noted that CPT code 93307 was last RUC reviewed in 2007; since that time there have been technological and clinical advances which allow for efficient review of additional images. The Intersocietal Accreditation Commission (IAC) standards last updated in 2015 require eleven separate imaging windows, with approximately 4-5 views per window (even without color Doppler or pulse Doppler). Quantitative evaluation of cardiac structures, such a left atrial volume, is now the expected standard. While digital

technology has afforded some improvement in intra service time, the physician no longer must passively wait as videotape advances, the volume and complexity of information to evaluate in the study has increased. The RUC agreed that this appropriately explains the increased intensity that results from maintaining the work RVU while slightly reducing the intra-service time.

The RUC compared 93307 to top key reference service 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.34 and 15 minutes intra-service time). The survey respondents indicated that 93307 is somewhat more intense/complex than 78454, however the intra-service times are identical (15 minutes). The specialty societies indicated that the intensity and complexity measures were higher for 93307, likely reflecting the more diverse disease processes to consider when the physician is reviewing the images. CPT code 93307 is a comprehensive cardiac study which includes measurements performed in the course of the examination, 2-dimensional and/or M-Mode numerical data for transthoracic echocardiograms and Doppler/color flow data. Whereas, CPT code 78454 is a planar imaging test to assess specific heart conditions including myocardial wall motion abnormalities with myocardial perfusion at stress and rest.

For additional support, the RUC referenced MPC codes 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU = 0.99 and 15 minutes intra-service time) and 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08 and 15 minutes intra-service time). **The RUC recommends a work RVU of 0.92 for CPT code 93307.**

93308 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study

The RUC reviewed the survey results from 167 cardiologists for CPT code 93308 and determined that the current work RVU of 0.53, lower than the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes of pre-service evaluation time, 10 minutes of intra-service time and 5 minutes immediate of post-service time. The RUC noted that CPT code 93308 was last RUC reviewed in 2011. This limited study is a problem-specific study, such a follow up for left ventricular ejection fraction in a patient undergoing chemotherapy. Once again, the array of tools now applied in this “limited” setting has advanced considerably since the last valuation. Use of contrast detailed analysis of regional ventricular function and quantitative assessment of ejection fraction are now routinely applied in “limited” echo studies, in stark contrast to the clinical standard at the time of the prior valuation. Additionally, while digital technology has afforded some improvement in intra service time, the volume and complexity of information the physician must evaluate for the study has increased. The RUC agreed that this appropriately explains the increased intensity that results from maintaining the work RVU while slightly reducing the intra-service time.

The RUC compared 93308 to top key reference service 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.34 and 15 minutes intra-service time). The survey respondents indicated that 93308 is somewhat more intense/complex than 78454. The specialty societies indicated that the intensity and complexity measures were higher for 93308, likely reflecting the more diverse disease processes to consider when the physician is reviewing the images. CPT code 93308 is

a cardiac study which includes measurements performed in the course of the examination, 2-dimensional and/or M-Mode numerical data for transthoracic echocardiograms and Doppler/color flow data. Whereas, CPT code 78454 is a planar imaging test to assess specific heart conditions including myocardial wall motion abnormalities with myocardial perfusion at stress and rest. CPT code 78454 requires 5 more minutes of intra-service time than 93308, which is balanced by the difference in work RVUs.

For additional support, the RUC referenced similar codes 78014 *Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)* (work RVU = 0.50 and 10 minutes intra-service time), 93882 *Duplex scan of extracranial arteries; unilateral or limited study* (work RVU = 0.50 and 10 minutes intra-service time) and 93979 *Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study* (work RVU = 0.50 and 10 minutes intra-service time). **The RUC recommends a work RVU of 0.53 for CPT code 93308.**

Practice Expense

The direct practice expense inputs were modified by reducing the clinical staff time in accordance with the two minute standard: line 21 *review prior images and report*, line 30 *prepare room, equipment, supplies*, and line 32 *Prepare and position patient/ monitor patient/ set up IV*. The Subcommittee also corrected line 71 the amount of *ultrasound transmission gel*, deleted line 73 *glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)* and replaced the vascular ultrasound room (EL016) with a general ultrasound room (EL015) thus eliminating the duplicative equipment. The RUC recommends the direct practice expense modifications as indicated by the Practice Expense Subcommittee.

Photodynamic therapy - PE Only (Tab 43)

Daniel M. Siegel, MD (AAD)

CPT code 96567 *Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session* was identified by Centers for Medicare and Medicaid Services (CMS) in the high expenditure services screen. The RUC recommended that this service be removed from the screen because it has a work RVU of 0.00. In the Final Rule for 2016 CMS indicated that this service should be reviewed.

In April 2001 CPT code 96567 was reviewed as new technology. The procedure involves application of a photo-sensitizing agent followed by exposure to special ultra-violet light. A survey of 39 dermatologists using this new technology indicated that there was some physician work for this XXX global period procedure. However, upon review of the survey responses, the specialty society concluded that the respondents did not accurately assess the time required by the physician for this procedure using the new technology and included a written recommendation that for the typical patient receiving this procedure, there is no physician work. The RUC agreed that the procedure, using this new technology, does not involve physician work but does involve practice expense direct inputs. Years later the service was nominated to be considered in 2005 Five-Year Review. The final Five-Year Workgroup report indicated that after extensive discussion with the RUC regarding the potential need for further CPT revisions, the RUC advised the specialty society that if physician work is part of the code then the specialty would need to submit a coding proposal to CPT to clarify the language to include physician work. At that time the specialty decided to instead withdraw the code from the Five-Year Review.

At the April 2016 RUC meeting the specialty society recommended that the service be deferred to the October 2016 RUC meeting in order for a survey of work to be conducted. The specialty explained that in reviewing the service closely, they realized that there is now physician work involved in providing this service. In order to confirm this observation, the specialty conducted an informal survey that was sent to a few dermatologists. The specialty contends that the results confirm that physicians are involved in the actual delivery of care to patients by performing tasks such as: curettage of thick lesions, real time tailoring of the PDT regimen, explaining side effects, and providing post care instructions. A RUC member questioned if any of the aforementioned services were separately billable and the specialty clarified that they are not. The specialty added that there has been no change to the service and that it is not necessary to refer to the code to the CPT Editorial Panel. A RUC member questioned why the specialty would be claiming that there is physician work now, when it was stated by the specialty that the service has not changed and in 2001 the specialty concluded that for the typical patient there is no physicians work as noted above. A RUC member suggested that there may be the need for two separate codes, one for a simple procedure that clinical staff can provide and one that is more complex and needs physician involvement. Another RUC member stated that the RUC does not have enough information to determine if the service should or should not go to CPT and ultimately that decision is up to the specialty society. The RUC member continued that this is an unusual service in that it usually is a two encounter service yet it is a single XXX global code. If they are going to survey for work the RUC advised that they go to CPT in order to separate this into two codes or at a minimum seek advice from the Research Subcommittee about how to survey for this type of service. The specialty indicated that it would submit a code change application to split code 96567 into two codes—one to describe physician work and one to describe the when the service is provided by clinical labor only. The specialty will submit a CCP for the September 2016 CPT meeting to address these concerns. **The RUC refers CPT code 96567 to the CPT Editorial Panel.**

Photochemotherapy - PE Only (Tab 44)
Daniel M. Siegel, MD (AAD)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. The RUC recommended that this service be removed from the screen because the work RVU is 0.00. In the Final Rule for 2016 CMS indicated that this service should be reviewed.

The specialty society explained that the technology for photochemotherapy has changed since this service was last reviewed in February 2001 from broadband UVB only to predominantly narrowband UVB. Patients are treated more aggressively resulting in longer treatment sessions and increased staff requirements. Moreover, due to increased energy output of bulbs, patients must be monitored more closely. The specialty also clarified that the typical patient receiving this procedure is a 47 year-old obese male patient with severe psoriasis with extensive body surface area involvement. The specialty explained that the occlusive dressings (ie impermeable sauna suit, nonlatex impermeable gloves and saran wrap) are applied over the tar. The sauna suit is listed as 0.5 units under supplies because it is used by the same patient for two separate treatment sessions. The specialty also verified that both the *phototherapy unit, hand-foot, UVA-UVB, EQ204* and *phototherapy unit, whole body, UVA-UVB, EQ205* are used for the typical patient and that the *phototherapy UVB measuring device EQ203* is only used for 2 minutes, rather than the entire service period.

The PE Subcommittee reviewed the direct PE inputs for CPT code 96910. The Subcommittee made the following modifications:

- Moved 2 minutes to *Other Clinical Activity - specify: Review physician orders and calculate dosage* from the post-service portion of the service period to pre-service portion of the service period.
- Verified that the sauna suit is used twice.
- Reduced the time to 2 minutes for equipment item *phototherapy UVB measuring device* EQ203 because it is not used for the entire service period and only requires 2 minutes of use, not directly corresponding to a line item on the spreadsheet.
- Modified the other equipment items *table, exam, EF023 light, exam, EQ168, phototherapy unit, hand-foot, UVA-UVB, EQ204* and *phototherapy unit, whole body, UVA-UVB, EQ205* to include the entire service period for the equipment minutes.

The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Home INR Monitoring (Tab 45)

Richard F. Wright, MD (ACC)

In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and these services were identified. In April 2016, the specialty society indicated that they intend to develop Category I codes to describe home INR monitoring services for the September 2016 CPT meeting with review at the January 2017 RUC meeting. **The RUC recommends that codes G0248, G0249 and G0250 be referred to CPT to create Category I codes to describe these services.**

XII. Practice Expense Subcommittee (Tab 46)

Doctor Scott Manaker, Chair, provided a summary of the report of the Practice Expense (PE) Subcommittee:

- **Practice Expense Spreadsheet Update Workgroup**
The Practice Expense (PE) Spreadsheet Update Workgroup, chaired by Doctor Ouzounian, has made substantial progress on an incremental improvement to the PE Spreadsheet. The Workgroup is categorizing all types of clinical staff activities in order to assign them a code number in the same way that supplies and equipment currently have code numbers. Assigning code numbers to clinical labor activities will better enable the PE Subcommittee to automate the PE spreadsheet, improving accuracy and reliability, as well as the ability to systematically input clinical labor activities into the CMS system. The draft spreadsheet will be circulated to specialty societies for input before we start piloting the new spreadsheet later this year.
- **Emergent Procedures Pre-Service Clinical Staff Time Review**
The report provides the status of the work that the PE Subcommittee did at this meeting to review the pre-service clinical staff time in the facility for codes identified as emergent. AMA staff has been able to develop a method of reliably combing through the data to identify emergent procedures that is now part of the standard materials circulated for the meeting. The PE Subcommittee has come up with a new pre-service time standard for emergent procedures

in the 090 day global period of 20 minutes reduced from 60 minutes. This standard has by and large been accepted by a broad range of specialty societies for many types of codes including the 090 day global closed fracture codes listed in the report as well as a single 010 day global closed fracture code.

- **New Business**

The PE Subcommittee discussed the CMS request that vignettes be available to the PE Subcommittee for review of PE only codes. There are currently two scenarios for PE only codes to receive vignettes. First, if a new code comes from the CPT Editorial Panel, a vignette will be included. However, these vignettes may need to be further vetted by the Research Subcommittee. Second, if a PE only code is an existing code and either has a vignette that needs to be revised or needs one created, the Research Subcommittee will review such requests.

Additionally at the PE Subcommittee meeting during review of the single view chest X-ray code it came to the Subcommittee's attention that for five percent of the claims, which was the majority of claims in the outpatient non-facility setting, the service is provided in a nursing home. This highlights the problems that the PE Subcommittee has in determining the typical service in the non-facility setting and the typical specialty society providing the service in the non-facility setting. Moving forward AMA staff will run claims data using the five percent Medicare file to narrow down the site of service for the non-facility setting. This information will be distributed early as part of the level of interest process, so that societies will better be able to determine if they need to participate in the survey and review process. This is important because even if the specialty is a minority provider in the universe of claims, they may in fact be the dominant provider in the non-facility setting and it is critical that they are involved in developing the PE recommendations as it would primarily affect them. This data will also help inform the PE Subcommittee's review as they determine the appropriateness of the specialty society's recommended direct PE inputs in the non-facility setting, especially as it relates to whether or not Evaluation and Management services are typically reported and which specialties are dominant in the non-facility setting.

Additionally, CMS asked that the description of clinical staff time be well articulated in the PE Summary of Recommendation document.

The RUC approved the Practice Expense Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 47)

- **Review of Action Plans**

Doctor Hitzeman informed the RUC that the Relativity Assessment Workgroup review action plans for two families of codes:

Continuous Glucose Monitoring (95250 and 95251)

In April 2013, CPT code 95251 was identified through the High Volume Growth screen and the RUC initially recommended survey 95251 and 95250 for January 2014. These codes went through review by CPT for a couple iterations to revise and ultimately were not revised. Even though volume has stabilized, since these services were initially recommended to be surveyed in 2013 and had not been surveyed, **the Workgroup recommended to survey 95250 and 95251 for October 2016. The Workgroup also recommended that CPT code 95251 be removed from the MPC list as questions exist whether this is a well-defined service to use as an anchor reference across the physician payment schedule.**

Physical Medicine and Rehabilitation (97101-97799 and G0283)

In February 2010, Physical Medicine and Rehabilitation services were first identified through the RUC’s High Volume Growth Screen and subsequently by Codes Reported Together 75% of the Time and from CMS via the High Expenditure screen. Since the original identification in 2010, the organizations have maintained that the section of CPT must be updated to describe today’s practice, prior to any analysis of valuation. A CPT Workgroup was formed in 2012 to address the coding issues. To date, there has not been any resolution. Therefore, the Workgroup reviewed an action plan to describing the work plan moving forward so review of these codes may occur. The specialty societies indicated which groups of codes they will be revising and when as outlined in the full Relativity Assessment Workgroup report. The review of these services will be completed by October 2017.

- **CMS/Other Source Codes – Utilization over 250,000**

Doctor Hitzeman indicated that the Workgroup had been reviewing the remaining G-codes that were identified via the CMS/Other source codes in April 2013. Realizing that some of these are Medicare only codes, we still noted that we have surveyed G codes and these services are very high volume. After discussion, the Workgroup recommends:

Code	Recommendation
G0179 G0180	Survey for work and review direct practice expense inputs for October 2016.
99375 99378	Survey for work and review direct practice expense inputs for October 2016. After review of 9937 and 99378, recommend to CMS to delete codes G0181 and G0182 as these are Category I and G codes are almost identical. Specialty society should identify any additional codes that are part of this family.
G0438 G0439	The Workgroup questioned the validity of the current values being crosswalked to level 4 Evaluation and Management services. Survey for work and review direct practice expense inputs for October 2016.

- **CMS/Other Source Codes - Utilization over 100,000**

Doctor Hitzeman indicated the Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000. **The Workgroup reviewed the list of 26 services and requested action plans to review in October 2016: 72020, 72072, 72220, 73070, 73090, 73650, 73660, 74220, 74420, 76000, 76870, 77012, 85060, 85097, G0101, G0108, G0109, G0166, G0402, G0403, G0436, G0442, G0444, G0447 and G0453.**

For the G-codes identified, the specialty societies should specify whether the service should go back to CPT to create a Category I code or be surveyed.

Peter K. Smith, MD reiterated that CMS and the specialty societies need to indicate what codes are part of a family of services to include in the survey process. Doctor Hitzeman indicated that we do request on the action plan and LOI forms that specialty societies indicate the family of services associated with each code identified via any relativity assessment screen.

The RUC approved the Relativity Assessment Workgroup Report and are attached to these minutes.

XIV. Time-Intensity Workgroup (Tab 48)

Doctor Scott Collins, Workgroup Chair, provided a summary of the Time/Intensity Workgroup report:

- **Presentation by STS on Past Experience with Directly Surveying Physician Intensity**
The Society of Thoracic Surgeons (STS) presented on the specialty's past experience with performing direct physician intensity surveys. Society of Vascular Surgeons' (SVS) is the other specialty that also has experience with performing direct intensity surveys. For direct intensity surveys, the intensity magnitude estimate asks the survey participant to estimate the average work intensity during the intra-service time of a survey code relative to average work intensities of other established codes contained in the intensity reference intensity list. The participant establishes relativity (rank order and degree of dispersion) between the code being surveyed and the intensities established for the codes in the Reference Intensity List. STS noted that the direct intensity survey methodology was validated in comparison to several Rasch analyses performed by the specialty. STS recommends for the RUC to approve this methodology for use outside of the former 5-year review process. The society also recommends that procedures be established for developing Reference Intensity Lists, so that these results can be deemed valid and utilized in a manner consistent with RUC precedents.

The Workgroup discussed this proposal in detail and asked several questions of the STS representatives. A Workgroup member shared an idea of potentially splitting the intra-service time into several distinct subparts and for intensity to separately be measured for each of those subparts. It was noted that the methodology for evaluating anesthesia services includes some of these elements.

Following this extensive discussion, the Workgroup thanked STS for volunteering their time and resources to prepare these materials and to present to the Workgroup. The Workgroup noted that they would continue to evaluate this presented idea along with other ideas for measuring work intensity. **Doctor Collins assured STS that their request for validation of the methodology outside of the previous 5 year review process would be maintained as an agenda item, and would be addressed at a future meeting.**

- **Discussion of New Ideas**
 - **Fly-in Meeting for Workgroup at AMA HQ:** The Time-Intensity Workgroup Chair proposed a fly-in meeting in Chicago for Workgroup. **Doctor Collins and AMA Staff will further evaluate a one or two day in-person meeting in Chicago for the Workgroup.**
 - **Intensity and Complexity (I/C) Measures**
Doctor Collins summarized the two main areas of concern stakeholders have expressed regarding the current intensity and complexity measures:
 - 1) **They are hard/time-consuming to interpret.**
For each survey code, there are 18 intensity/complexity scores listed on the SOR and those scores are very small numbers that go out to the second decimal point. With the RUC reviewing ~100 codes per meeting, there is simply too much information to be able to review it all effectively.

2) Questions about the validity of the underlying data.

This stems largely from the responses tending to most commonly indicate that the survey code is somewhat more intense than the reference code. It is unclear whether this is due to a flaw in the survey design or because, for the initial selection of the key reference code, the survey respondents just tend to select reference codes that are typically somewhat less intense than the code under survey for some unknown reason.

Doctor Collins proposed to address the first issue and that the second issue be addressed at a later date. The Workgroup can attempt to revise the intensity and complexity scores without making changes to the survey instrument.

- **The Workgroup discussed the following ideas regarding the summary data for the intensity and complexity measures:**
 - **Show average responses text in summary data:** What the survey respondent is actually asked to provide is not numeric, but text choices indicating whether the survey code "much less" to "much more" intense/complex relative to the selected key reference service. The -2, -1, 0, +1 +2 scale is simply assigned to corresponding text choices behind the scenes in the raw data. If the summary data was also (or only) reported as the actual underlying text choice (i.e. if score is between 0.51 and 1.49, it could say the survey code is "somewhat more intense" than the reference code), that may make the information easier to interpret.
 - **Aggregate Score:** Prove average scores for each of three categories of "mental effort and judgment" and "psychological stress." For example, there are three I/C questions that fall under "mental effort and judgment"; those 3 summary scores could be averaged into a single score. This could also be done for the "psychological stress" category.
 - **Reordering Overall Intensity Summary score:** Although the overall I/C question is last on the actual survey, this score may be more helpful displayed first on the SOR to provide RUC members with a quick point of reference.

The Time-Intensity Workgroup recommends for a pilot test of these three proposed ideas to be performed by all societies surveying for the October 2016 RUC meeting for every survey code. This alternate summary data would be provided as a 1 page addendum to the SOR. The Workgroup requested for AMA staff to create instructions for specialty staff on how to implement this pilot.

- **Ideas for Validation of Physician Time and Intensity**
 - **Surveying intra-service work directly:** Doctor Collins proposed the idea of surveying for intra-service physician work RVUs in addition to, or even instead of surveying total work RVU. He noted that although this does not survey directly for intensity, it does allow a direct calculation of intensity from two directly surveyed values. The Workgroup discussed this idea with some members expressing interest in exploring this idea further.
 - **Ranking surveys:** Separately from RUC survey, send out a separate survey asking respondents to simply rank a group of codes in order of their intraservice intensity and/or time and/or intraservice work. The purpose of this idea is internal validation of existing rank orders and intensities to make sure they have appropriate rank order.

Doctor Collins noted that he and AMA staff will provide a more detailed draft to share with the Workgroup at a future meeting.

- **Inserting survey code into a reference service list;** "Insert" survey code into a static reference service that is ordered by either intensity or work - this code fits between code a and b and then the respondent is asked to answer intensity questions about those two code in relationship to the new/code under review. The respondent would then be asked to compare the I/C of the survey code to the two codes it was inserted in between. Several Workgroup members expressed general interest in hearing more about this idea.
- **Review of Survey Intensity/Complexity Measures: Mean vs. Median**
The Workgroup briefly discussed this item and there were no Workgroup members that expressed interest in switching from mean to median.
- **Discussion: Statistical Analysis of RUC Time Data**
The Chair noted that this will be explored further by consulting an AMA Senior Economist. AMA RUC Staff will meet with an economist from the AMA Economic and Health Policy department several times prior to the October 2016 RUC meeting to discuss potential additional descriptive and analytic statistics to include in the SOR. A report of the additional ideas that come from these meetings will be presented to the Workgroup in October. An invitation will be extended for the AMA Economist to attend the October Time-Intensity Workgroup meeting to have a discussion with the workgroup.

In addition, Doctor Collins noted that the Workgroup's recommendation to update the physician time question so survey respondents are asked to make more precise time estimates instead of rounding to the nearest 5 or 15 minute increments will be evaluated by the Research Subcommittee at this RUC meeting.

- **Discussion: Intra-service Work Per Unit of Time (IWPUT)**

The Workgroup briefly discussed IWPUT during their brainstorming session of several ideas earlier in the meeting.

The RUC approved the Time-Intensity Workgroup Report.

XV. Emerging CPT/RUC Issues Workgroup (Tab 49)

Doctor Raphaelson provided a summary of the Emerging CPT/RUC Issues Workgroup report:

- **An Update on CPT Editorial Panel Review of Care Collaboration/Non Face-to-Face Coding Proposals (April RUC tabs 4 & 5)**
Doctor Ellington summarized two innovative sets of codes recently approved by the CPT Editorial Panel:

Psychiatric Collaborative Care Management Services – three new codes were developed to capture a new practice model which involves the collaboration of a Primary Care Provider, a behavioral manager, and a Psychiatrist to provide management of psychiatric needs. These codes are being discussed by an Ad Hoc Workgroup of the Research Subcommittee to troubleshoot the survey needs for the October RUC meeting.

Cognitive Impairment Assessment and Care Plan Services – one new code was developed to capture a collaboration with an assessment and care planning for a patient with cognitive impairment. This code was surveyed and is being reviewed at this RUC meeting.

- **Physician Focused Alternative Payment Models**

Harold Miller delivered a presentation “Tools Needed to Design and Implement Physician-Focused Payment Models.” The full presentation is available on the RUC Collaboration Site in the *Handouts at the Meeting* folder.

- **Discussion/Next Steps**

There was general discussion regarding potential coding needs related to the implementation of alternative payment models (APMs), as specified by MACRA. The CPT Editorial Panel and the RUC may need to discuss new types of codes for alternative payment models. CPT Editorial Panel members indicate that they will discuss these issues at a strategic session at the May CPT meeting.

RUC has valued alternative models, such as medical home, and RUC is now preparing to value psychiatric care collaboration. Workgroup members agreed that an accurate relative value system will remain the basis for valuation of many future episodes of payment and for calculating payments to multiple providers engaged in an episode.

The Workgroup passed the following motion by consent vote: To recommend that the CPT Editorial Panel discuss at their strategic session how potential codes for APMs could be developed and categorized and that the RUC is involved as appropriate in the valuation of codes similar to the work done to date.

Members discussed the need for specialties to collaborate on a multi-disciplinary models, taking into consideration which physician would be responsible for collecting payment and dispersing payments to other involved physicians or other qualified health care professionals.

Mr. Miller described the HHS Physician Focused Technical Advisory Committee. The proposed process may be found at (<https://aspe.hhs.gov/medicare-access-and-chip-reauthorization-act-2015>). The next meeting is May 4th and those wishing to attend can register online.

XVI. Administrative Subcommittee (Tab 50)

- **Review Election of Rotating Seats Submission – Tab 53**

Doctor Waldorf informed the RUC that the Administrative Subcommittee reviewed the nominations for the internal medicine rotating seat, Timothy Laing, MD, American College of Rheumatology, and the primary care rotating seat, Julia Pillsbury, DO, American Academy of Pediatrics. The Subcommittee noted that the internal medicine rotating seat and primary care rotating seat each had one nominee, therefore “an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote.”

- **Non-Staff Representation Agreement**

Doctor Waldorf indicated that this item has been pulled from the agenda. The non-staff representation agreement form was initiated via the CPT Editorial Panel and is still undergoing review. In May, the Panel will hold a facilitation meeting explaining why this form was created, who should complete it and answer any questions. Therefore, the RUC will

wait until the CPT Editorial Panel has this facilitation and any further edits to the document before the Administrative Subcommittee reviews.

XVII. Research Subcommittee (Tab 51)

Doctor Doug Leahy, Chair, provided a summary of the Research Subcommittee report:

- **The Subcommittee reviewed and accepted the February 2016 Research Subcommittee conference call report.** Doctor Leahy also stated that the Subcommittee would work to get Research Subcommittee calls scheduled further out in advance going forward.
- **General Survey Instrument and Memo Text Update**

AMA Staff provided draft language for the Subcommittee to review as requested by Research Subcommittee on a December 2015 conference call. **The Research Subcommittee approved the language as follows:**

- ***For first page of RUC Online Survey Tool:***
“IMPORTANT: Please check CPT codes for procedures/services that you have experience performing or are familiar with. Please select all of the CPT Codes that apply to you. You will only be surveyed about each code that you select.”
- ***For first page of Other Survey Tools (ones which do not have the capability to display only survey questions from selected survey codes):***
“IMPORTANT: Please only respond to questions for survey codes that you either have experience performing or are familiar with.”
- **Updated Text for Cover Memo:**

“You have been selected to participate in an AMA RUC survey. As you may know, the Medicare payment schedule is based on physician work, practice expense and professional liability insurance. Our society needs your help to assure relative values will be accurately and fairly presented to the Centers for Medicare and Medicaid. **Please note, you do not need to respond to the questions for all of the codes in this survey. You may not have recent experience with one or more of the procedures. We ask that you provide responses for those services about which you have direct professional knowledge and feel comfortable answering, whether or not you currently perform the service.**”

REMINDER: This survey is to be completed independently without coaching or assistance, with the exception of clarification from specialty society staff. If you are inappropriately contacted regarding this survey, please notify specialty society staff immediately.”

At the December 2015 Time-Intensity Workgroup meeting, as part of a discussion on measuring physician time, several Workgroup members noted that survey results often appear that the survey respondents tend to round to the nearest 5 minute or 15 minute increment instead of providing estimates to the nearest minute. The Workgroup requested for AMA staff to draft language for the Research Subcommittee to consider at the April meeting. **Following an extensive discussion, the Subcommittee did not make a final decision on the updated text and instead, referred this issue to the Time-Intensity Workgroup for further discussion.**

- **23-hour stay outpatient surgical services with post-operative visits and New Standard Survey Template for 000-day surgical with visit**

At the Subcommittee meeting prior to the January RUC meeting, the Subcommittee requested for AMA staff to draft instructions explaining how to implement CMS' policy related to 23-hr outpatient surgical codes with post-operative visits. The Subcommittee also requested for an alternate 000-day template to be drafted. The Subcommittee should review the below text and the draft alternate 000-day template and discuss if they should be implemented.

23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy

CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as *23-hour stay outpatient services*. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to include bundle subsequent hospital visits (e.g. 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intraservice portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure.

If the survey results indicate that a 23-hour stay with a subsequent hospital visit is typical and the Medicare claims data (if available) show that the service is typically performed in the outpatient setting, then the surveying specialties may add the post-operative visit intra-service time to the immediate post-operative physician time and not list a subsequent hospital visit in the recommendation. For example, if the survey data for a 23-hour stay code includes 15 minutes of immediate post-service time and one 99232 post-operative visit (20 minutes of intra-service time), then the recommendation could include 35 minutes of immediate post-service time and no subsequent hospital visit.

Absent Medicare claims data, the specialties may determine whether the service is outpatient via expert panel. Also, when preparing to survey a 000-day global codes which may potentially be a 23-hour stay code with a visit, please be sure to use a RUC survey template which collects site of service, hospital stay and post-op visit data. For 000-day surgical services, specialties should provide additional documentation which supports that a subsequent hospital visit is typical on the day of surgery.

The Subcommittee reviewed the proposed instructions and alternate 000-day survey instrument (as provided in the agenda materials) and approved both without modification.

- **Review of Proposed Text for RUC Survey Instrument videos**

At the October 2015 RUC meeting, as part of a review of survey process recommended from specialty societies, the Subcommittee noted that the creation of a video explaining the RUC survey process to potential survey respondents would be beneficial. AMA staff drafted three separate videos to be made: one for surgical services (000-day, 010-day, 090-day services), one for other physician services, and a third video applicable to HCPAC societies. AMA staff sent the draft scripts to a dozen specialty societies for review. Specialty societies provided many helpful edits, most of which were incorporated into an updated drafts provided to the Subcommittee for the April 2016 meeting.

The Subcommittee noted that overall these PowerPoints and scripts are appropriate and should be useful to potential survey respondents. One observer noted that a sentence stating that typical is more than 50% of the time on slide 12 should be deleted and the Subcommittee agreed. The Subcommittee also requested for AMA Staff to delete the last PowerPoint bullet on slide 4 and slide 6. In addition, the Subcommittee requested for AMA staff to replace the term “reference service(s)” on slide 14 that is easier to understand for those that are not familiar with the RUC process. **The Research Subcommittee approved the survey video scripts and PowerPoint slides with the minor modifications as described above.**

- **Initial Discussion: Survey sample numerator and denominator**

At the last Research Subcommittee meeting, an observer questioned whether the survey response rate could be calculated in some other statistically-valid way (for example, if only those that actually opened the email could be counted). Following up on this discussion, AMA RUC staff met with AMA Senior Economist Carol Kane, PhD, from the AMA Economic and Health Policy Research team in early March. Dr. Kane explained that modifying the survey response rate denominator based on whether an individual opened an email is not a method that would be considered appropriate or that she has ever seen it used for any research studies. She did point out though that there are valid methods for calculating the survey response rate that the RUC does not currently use. Dr. Kane explained how the RUC could use a similar method as her group used to calculate the survey response rates for the AMA 2007 Physician Practice Information (PPI) survey. This method involves calculating an expected eligibility ratio for the survey pool and reducing the survey sample denominator by this expected eligibility ratio.

Several Subcommittee members expressed general interest in this idea, while others noted that this idea would only be appropriate if the change would have a large enough impact to make the additional work needed of specialty staff worthwhile. **The Research Subcommittee requested for AMA staff to solicit a few societies test this new proposed idea. The Subcommittee will review this information at its October meeting.**

- **Review of Existing RUC and CPT Vignette Instructions**

The Research Subcommittee reviewed the existing instructions for creating vignettes as provided by the RUC and CPT Editorial. **The Subcommittee did not propose any modifications to the existing instructions and reaffirmed the RUC’s existing vignette instructions.**

- **Esophagectomy Vignette Review (43286-88, 43107, 43112, 43117)**

The Research Subcommittee reviewed the vignettes as submitted by the specialty societies. Several Subcommittee members questioned the typicality of neoadjuvant chemotherapy for 432X6-7, 43112 and 43117. The societies confirmed that neoadjuvant chemotherapy is typical for these services. In addition, a Subcommittee member cited guidelines from the National Comprehensive Cancer Network (NCCN) which further supported that the inclusion of neoadjuvant chemotherapy was appropriate. **The Research Subcommittee approved the vignettes as originally proposed by the specialty societies:**

43286 Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastronomy (ie, laparoscopic transhiatal esophagectomy)

Approved Vignette: A 72-year-old man presents with a history that includes gastroesophageal reflux, progressive dysphagia and testing that revealed a distal esophageal adenocarcinoma arising within long segment Barrett's esophagus with multifocal high-grade dysplasia. He undergoes esophageal resection and reconstruction.

43287 Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (ie, laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)

Approved Vignette: A 65-year-old woman presents with one month history of progressive dysphagia. Testing revealed a distal esophagogastric junction adenocarcinoma. She received neo-adjuvant chemotherapy and radiation therapy. She now undergoes surgical resection.

43288 Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle, and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, thoracoscopic, laparoscopic and cervical incision esophagectomy, McKeown esophagectomy, tri-incisional esophagectomy)

Approved Vignette: A 70-year-old man presents with progressive dysphagia. Testing revealed a mid-esophageal adenocarcinoma above the level of the carina. He received neoadjuvant chemotherapy and radiation therapy. He now undergoes surgical resection.

43107 Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)

Approved Vignette: A 72-year-old man presents with a history that includes gastroesophageal reflux, progressive dysphagia, and testing that revealed a distal esophageal adenocarcinoma arising within long segment Barrett's esophagus with multifocal high-grade dysplasia. He undergoes esophageal resection and reconstruction.

43112 Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy, or tri-incisional esophagectomy)

Approved Vignette: A 70-year-old man presents with progressive dysphagia. Testing revealed a mid-esophageal adenocarcinoma above the level of the carina. He received neoadjuvant chemotherapy and radiation therapy. He now undergoes surgical resection.

43117 Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)

Approved Vignette: A 65-year-old woman presents with one month history of progressive dysphagia. Testing revealed a distal esophagogastric junction adenocarcinoma. She received neo-adjuvant chemotherapy and radiation therapy. She now undergoes surgical resection.

- **Other Business**

- **Psychiatric Collaborative Care Management Workgroup Reports** (*Informational Only*)

Doctor Andreae, the Chair of the Workgroup, provided a general overview of the workgroup's report from its April 11 conference call. Doctor Andreae noted that the specialties plan to survey these services for the October 2015 RUC meeting. The Workgroup requested for the specialties to pull together a detailed plan for surveying and valuing these codes for the October RUC Meeting. The Workgroup will review and provide guidance before these items go to the Research Subcommittee for approval. The next Workgroup call will need to be scheduled for mid-May in preparation for the early June Research Subcommittee meeting. One issue that was a point of contention for the Workgroup was whether the work of the contracted psychiatrist should fall under practice expense. The Workgroup and Research Subcommittee each noted that the RUC does not have to make this determination as part of its future recommendation, instead leaving the decision to CMS. **The Research Subcommittee approved the report as submitted.**

- **Anesthesia Workgroup Report** (*Informational Only*)

Doctor DiSesa, chair of the Anesthesia Workgroup, provided a general overview of the workgroup's report from its April 12 conference call. The Specialty will present 6 new proposed codes to CPT for describing anesthesia for upper and lower GI endoscopy services at the October 2016 CPT meeting and plan to survey these services for the January 2017 RUC meeting. The Workgroup requested for the specialty society to proceed with taking their CPT proposal to CPT for the October 2016 CPT meeting. The Workgroup made it clear that they did not provide specifically approve the coding language or the proposed vignettes. **The Workgroup requested for the specialty to send the vignettes for these services to Research for review and approval prior to surveying these services and the Specialty agreed.**

The Workgroup noted that it did not re-validate the individualized PIPPA work RVU methodology, but agreed that the RUC should value these services according to the present methodology, using the RUC anesthesia survey instrument and process.

The Workgroup recommends an educational presentation be provided to the RUC on the existing survey and valuation process for anesthesia services since it has not been validated or used for a survey since 2007, including a specific example of how the data from a survey are used to value an anesthesia service.

The Workgroup requested that anesthesia codes be included in any RAW screens.

The Research Subcommittee approved the report, which is available in tab 51 of the agenda materials, as submitted.

- **Survey Question Proposal from RUC Member:**
Following the Research Chair's presentation, a RUC member suggested for the Subcommittee to consider adding a survey question that would determine if the survey respondent has experience performing the survey code in the recent past, the distant past or is simply familiar with the service. The RUC member suggested that this would allow the Research Subcommittee and the RUC to assess the continued viability of allowing survey respondents to complete the survey that are only familiar with the service. **The Research Subcommittee Chair noted that the Subcommittee would evaluate this proposal at an upcoming meeting.**

The RUC approved the Research Subcommittee Report.

XVIII. HCPAC Review Board (Tab 52)

Dr. White provided a summary of the HCPAC Review Board Report:

- **RUC Process**
As requested at the January 2016 HCPAC meeting, the HCPAC members were provided with materials regarding the RUC process. AMA staff referenced the presentation, which is included in the meeting agenda introduction materials, to provide an overview of the RUC process for valuation of codes and the screens used to identify potentially misvalued codes. The HCPAC walked through the discussion checklist and a reference SOR to highlight where the items are found that a reviewer should verify. The HCPAC also discussed the presentation guidelines where the instances requiring compelling evidence are detailed. Finally, Dr. White mentioned that we will continue to expect all HCPAC members to review tabs that come through the process and to provide comments on the reviewer comment schedule.
- **HCPAC MPC List Review**
The HCPAC discussed the need to review and update the HCPAC MPC list. Many of the codes on the current list have not been reviewed for a number of years and it was determined that it is beneficial during the survey process to have this list up to date. A request went out to the HCPAC specialties before this meeting to ensure each specialty evaluated their codes from the current list. The HCPAC walked through the MPC Summary of Process document noting that although codes from the HCPAC may not be able to meet all of the criteria listed, the group will aim to get codes as close to these recommendations as possible.

The HCPAC further discussed the spreadsheet of codes performed by HCPAC providers and the highlighted recommendations from specialties for changes to the MPC list. The HCPAC reviewed that additions, retentions, and deletions have been provided by six specialties. A discussion was held about how we should handle codes going to CPT and it was mentioned that codes under revision should be monitored and that the continuous review of the list would allow for these to be addressed in a timely fashion. Additionally the Committee noted that this might initially be a larger task to update given a lot of revisions occurring in code sets but that an updated list is critical during the survey process.

The HCPAC discussed how and when the group wishes to update the MPC list moving forward. It was decided that an initial review and vote would be conducted at the October 2016 HCPAC meeting. Additionally, the HCPAC would plan to keep the list review as a standing agenda item to review specialty recommended changes at each meeting but would opt to publish the changes from multiple meetings in a new version once a year in January of each year. Finally, the HCPAC discussed that the Chairs and AMA Staff would assign

HCPAC member reviewers to review the submitted MPC list change recommendations in preparation for the October HCPAC vote.

XIX. Rotating Seat Election (Tab 53)

- Julia Pillsbury, DO, American Academy of Pediatrics (AAP) was elected to the RUC's Primary Care rotating seat.
- Timothy Laing, MD, American College of Rheumatology (ACR_h) was elected to the RUC's Internal Medicine rotating seat.

XX. Other Business (Tab 54)

- The American College of Surgeons (ACS) requested a discussion regarding the intensity value of 0.0081 that is assigned to the pre-time component of "scrub, dress, wait." Specifically, ACS believes a review of the intensity calculations could be beneficial. **The RUC approved referring this issue to the Time-Intensity Workgroup.**
- The American College of Obstetricians and Gynecologists (ACOG) requested a discussion regarding CMS trends of rejecting RUC recommendations based solely on their time analysis/methodology. The RUC agreed that intensity is just as important as time and it should be reiterated that CMS should adhere to statute, where both time and intensity are both required to be considered. **The RUC will include a discussion of this issue in a May letter to CMS to accompany the RUC recommendations.**
- Doctor Peter Smith presented a discussion about the AAD Skin Biopsy tab previously discussed at the January RUC Meeting. At that time, the issue was referred to CPT for revision and would come back to the RUC after a re-survey. An article was subsequently published which may provide a potential conflict for the re-survey process. Discussion included suggestions of 1) asking the survey respondents if they received any correspondence or information about the time and work of the codes in question; 2) looking for participants who were not originally surveyed; 3) comparing the survey findings from the previous and new survey; 4) using auxiliary data from office logs to better support the recommendation; and/or 5) not reminding those participating in the survey of the article. **The RUC decided to refer the issue to the Research Subcommittee for guidance on how to properly re-survey these codes.**
- Doctor Peter Smith discussed his preference all specialties utilize the same electronic survey system to ensure fairness, transparency and accountability throughout the process.

Compelling Evidence

- A RUC member requested review of the compelling evidence standards regarding the definition and rules.
- Another RUC member noted that when reviewing these standards, the following specific language should be added "In the case when a code is resurveyed and CMS did not accept previous recommended RUC value, compelling evidence based on flawed mechanism (CMS unilateral decision) can be used to recommend a value that is equal to the previous RUC recommended value, but additional compelling evidence would need to be presented if recommended value is higher than the previous recommended value".

- A RUC member requested that in review of the compelling evidence standards that the RUC consider more examples of compelling evidence (i.e., low (to be defined) or negative IWPUT). Low or negative IWPUT may be an indicated that a service is improperly valued and that compelling evidence that it should be reviewed. **The Administrative Subcommittee will review the RUC's compelling evidence guidelines.**

Low or Negative IWPUT

- A RUC member requested that the Relativity Assessment Workgroup review services with low or negative IWPUT as a possible screen. **This issue will be referred to the Relativity Assessment Workgroup.**