

**AMA/Specialty RVS Update Committee
Meeting Minutes
January 24-26, 2013**

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, January 25, 2013 at 8:00 am.
The following RUC Members were in attendance:

Barbara Levy, MD	Sandra B. Reed, MD
Michael D. Bishop, MD	J. Allan Tucker, MD
James Blankenship, MD	James C. Waldorf, MD
Albert Bothe, MD	George Williams, MD
Joel Bradley, Jr., MD	Allan A. Anderson, MD*
Ronald Burd, MD	Margie C. Andreae, MD*
Scott Collins, MD	Gregory L. Barkley, MD*
John O. Gage, MD	Gregory DeMeo, MD*
William F. Gee, MD	Jane Dillon, MD*
Anthony Hamm, DC	William D. Donovan, MD, MPH, FACR*
David C. Han, MD	Jeffrey Paul Edelstein, MD*
David F. Hitzeman, DO	Yul Ejnes, MD*
Charles F. Koopmann, Jr., MD	William E. Fox, MD, FACP*
Stephen Lahey, MD	Gilbert Johnston, MD*
Timothy Laing, MD	Daniel McQuillen, MD*
Walt Larimore, MD	Margaret Neal, MD*
Alan Lazaroff, MD	Scott D. Oates, MD*
J. Leonard Lichtenfeld, MD	Daniel Mark Siegel, MD*
M. Douglas Leahy, MD, MACP	Norman Smith, MD*
Brenda Lewis, DO	Holly Stanley, MD*
Scott Manaker, MD, PhD	Robert J. Stomel, DO*
Larry Martinelli, MD	G. Edward Vates, MD*
Geraldine B. McGinty, MD	Thomas J. Weida, MD*
Eileen Moynihan, MD	Jane White, PhD, RD, FADA, LDN*
Daniel Nagle, MD	Jennifer L. Wiler, MD*
Gregory Przybylski, MD	Fredrica E. Smith, MD*
Marc Raphaelson, MD	

*Alternate

II. Chair's Report

- Doctor Levy welcomed everyone to the RUC Meeting.
- Doctor Levy welcomed the following Center for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting:
 - Edith Hambrick, MD – CMS Medical Officer
 - Steve E. Phurrough, MD – CMS Medical Officer
 - Via Conference Call
 - Kathy Bryant - Director of the Division of Practitioner Services
 - Ryan Howe – Senior Policy Analyst

- Doctor Levy welcomed the following new RUC members and alternates:
 - Stephen Lahey, MD – RUC Member, Society of Thoracic Surgeons
 - Gilbert Johnston, MD – RUC Alternate, Society of Thoracic Surgeons
- Doctor Levy welcomed the following Contractor Medical Directors:
 - Richard W. Whitten, MD, MBA, FACP
 - Mitchell D. Resnick, DO, MBA, MPH
- Doctor Levy welcomed the following observers:
 - Peter Braun, MD, Consultant, Urban Institute
 - Barbara Wynn, Senior Health Policy Analyst, RAND
- Doctor Levy laid out the following guidelines related to RUC proceedings:
 - There is a confidentiality policy that needs to be signed at the registration table for all RUC members and alternates.
 - Proceedings are recorded in order for RUC staff to create the meeting minutes.
 - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue.
 - RUC members or alternates sitting at the table may not present or debate for their specialty. The RUC is an expert panel and individuals are to exercise their independent judgment and are not advocates for their specialty.
- Doctor Levy laid out the following guidelines related to voting:
 - The RUC vote count will be published as previously outlined by the Administrative Subcommittee. The votes will be published following the November 2013 Final Rule for the 2014 Medicare Physician Payment Schedule
 - Voting will occur on every work RVU, including facilitation reports and practice expense.
 - RUC members should share voting remotes with alternates if unable to be at the table.
 - To insure 28 votes are collected for each code, re-voting may be necessary throughout the meeting.
 - If members are going to abstain from voting or leave the table please notify AMA staff so we may account for all 28 votes
- At the end of February, Doctor Levy will be joining Doctor Peter Hollmann, Chair of the CPT Editorial Panel and several other key CPT/RUC members, in meeting with John Blum, Deputy Administrator at the Center for Medicare & Medicaid Services (CMS). The focus of the meeting will be on finding ways to better communicate between the CPT process and CMS. If there are overarching issues that RUC participants agree should be discussed, please relay these to the Chair during this meeting.

III. Director's Report

- The AMA is getting outside bids to make some major improvements to the RUC database including making it Mac compatible and allowing downloading online rather than relying on CDs. This should be available this time next year.
- This year several improvements have been made to the 2013 RUC database, including:
 - Work RVU history
 - This new tab indicates the complete history of work RVUs for a given CPT code. You will note volatility early in the Medicare Payment Schedule due to Medicare initially applying work neutrality directly to the work RVUs, where currently it is applied to the conversion factor.

- You will also see varying increases resulting from the 1st Five Year Review RUC recommendations, 3rd Five Year Review RUC recommendations and the elimination of the consultation codes.
- Medicaid claims data from 2009
 - Data is included for every state except Indiana
 - Place of service is made available; however specialty data is currently not reliable and was not included.

IV. Approval of Minutes of the October 4-6, 2012 RUC Meeting

The RUC approved the October 2012 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

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

- The CPT Panel met in October in Memphis. Doctor Collins attended the meeting as the RUC representative.
- Tab 3 in your agenda book contains the following two documents:
 - New and Revised CPT 2014 Status Report
 - Includes new CPT codes and the further refinement of the Qualified Health Care Professional terminology.
 - CMS Requests and Relativity Assessment STATUS-Jan 2013
- There are six Workgroups currently active at CPT that will be delivering a work product to the RUC over this coming year. They include another look at moderate sedation, better descriptors for physical medicine and rehab, a review of the language around the global surgical package, an effort to define applied behavior analysis and interventions and the three components of Evaluation and Management.
- The National Institutes of Health (NIH) has agreed to adopt the CPT molecular pathology coding scheme for use in its genetic test registry. This will make it more useful and provide crosswalks.

Doctor Charles Koopmann provided the following update of the Mandated Services Workgroup:

- The Workgroup presented their recommendations to the CPT Editorial Panel at the October meeting. The recommendations were to consider new codes for mandated services. There is currently no word on whether or not this issue will proceed, but CPT is currently considering it.

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

Doctor Edith Hambrick provided the report of the Center for Medicare and Medicaid Services (CMS):

- The Agency extends its thanks to the RUC for all the timely work done on the transitional care management codes.

- There are some staff changes at the agency.
 - Mark Hartstein has been confirmed as the Director of Hospital and Ambulatory Policy Group.
 - Christine Smith-Ritter who was previously the Director of the Division of Practitioner Services has been promoted to be the Deputy Director of Hospital and Ambulatory Policy Group.
 - Kathy Bryant is now the Director of the Division of Practitioner Services
 - The Agency is currently looking for a Deputy Director of the Division of Practitioner Services.
 - The Centers for Medicare & Medicaid Services (CMS) has put out a bid to develop a validation model for the work component of the Medicare physician fee schedule. Information on each of the contractors being considered has been distributed at this meeting.
 - If there is anything that needs to be discussed with the Agency to be considered for the 2014 Medicare Proposed Rule, now is the time to do so.

VII. Contractor Medical Director Update (Informational)

Doctor Richard W. Whitten, MD, FACP provided the contractor medical director update:

- CMS intends to continue to consolidate jurisdictions and move from a total of 15 contractors down to 10.
- Contractor updates
 - Jurisdiction L A/B MAC contract was awarded to Novitas Solutions, Inc. in September. Two protests were filed and it will likely be early summer before there is a decision.
 - Jurisdiction 6 A/B MAC contract was awarded to National Government Services, Inc. (NGS). Protests were filed and that contract was resolved recently. The contract remains with NGS. Over time jurisdiction 6 will be consolidated and become jurisdiction G.
 - Jurisdiction E A/B MAC contract was awarded to Noridian Administrative Services in September. Protests were filed and that contract was recently resolved.
 - The protests are likely to continue as this is common in government contracting. Congress has authorized protests to be filed on a five year basis.
- Durable Medical Equipment contracting has 4 jurisdictions.
 - Jurisdiction A Durable Medical Equipment (DME) MAC contract has been with National Health Insurance Core for some time.
 - Jurisdiction B Durable Medical Equipment (DME) MAC contract has been with NGS for some time.
 - Jurisdiction D Durable Medical Equipment (DME) MAC contract has been with Noridian for some time.
 - Jurisdiction C Durable Medical Equipment (DME) MAC contract has been awarded to CGS Administrators, LLC in September. Previously CGS was Cigna in September. Protests were filed, but resolved.
 - The Durable Medical Equipment contractors should be stable for the next 4 years.

- Sections 6407 of Affordable Care Act will result in a separate issue for DME Prosthetics, Orthotics or Supplies. It reads:
 - A physician must document that the physician, PA, NP or CNS has had a face-to-face exam with a beneficiary in the 6 months before a written Rx.
 - 155 items covered under the requirement.
 - A physician documenting a PA, NP or CNS' visit will be able to bill a separate G code.
- CMS RACs
 - Jurisdiction A - Diversified Collection Services, Inc. of Livermore , CA
 - Jurisdiction B- CGI Technologies and Solutions, Inc. of Fairfax, VA
 - Jurisdiction C- Connolly Consulting Associates, Inc. of Wilton, CN
 - Jurisdiction D - HealthDataInsights, Inc. of Las Vegas, NV
 - RACs now changed to Recovery Auditors
 - There may be some slight changes to the districts with the re-contracting requirements that will come out in the next few months.
- ZPICs have taken over from the program safeguard contractors. The ZPICs deal with fraud. If a member receives a letter treat it seriously.
- The Office of the Inspector General deals with post pay. Please look for the 2013 OIG report for information about Medicare A and B contract activities. You will want to look at what the announced activity for the year will be regarding post pay review.
- Previously contractors had been able to share information with physicians and specialty societies and in recent years there was then a shift away from that. This is currently being reversed and contractors are now able to share more information. This has led those who create the LCDs to meet regularly. The focus is to share information that goes into the LCDs including: literature; literature reviews and interaction with stakeholders providing input. This is a unique opportunity for the specialty societies to look at topical LCDs. There is going to be an effort to consolidate, so it is a good opportunity to share opinions about LCDs that have been helpful and those that have not.
- LCD Development process:
 - Contractor charged to develop a policy if no policy exists and it has been pointed out that there is a deficit.
 - Purpose of the CAC is to be on LCDs
- LCD Reconsideration Process
 - This is a good time to try to make changes to the LCDs because there is a national focus on the language and requirements.
- The CMS website has resources to find your local contractor medical directors.

VIII. Washington Update (Informational)

Sharon McIlrath, AMA, provided the RUC with the following information regarding the AMA's advocacy efforts:

- Partisan bickering created gridlock in the 112th Congress.
- The 33 House votes on ACA repeal made it impossible to implement technical corrections as would normally be done.
- No budget passed and there was a delay on: SGR repeal and deficit reduction as well as other issues.

- Congress did pass a temporary reprieve (American Taxpayer Relief Act) on New Year's Day that included the following physician provisions:
 - Averted a 26.5% cut in Medicare conversion factor (CF).
 - Extended 1% work GPCI floor.
 - Did not stop other 2013 payment changes from the Final Rule.
 - Expanded PQRS to include clinical data registries.
 - 2 month delay in sequester
 - 2% cut in Medicare payments and even higher cuts for NIH, public health, etc.
 - Many believe that it will go into effect, but will be stopped as other budget issues come up.
- SGR fix will be in effect through the end of 2013 and cost \$25 billion
 - Half of the cost paid for by hospitals
 - Includes coding intensity adjustment (\$10 billion).
 - Imaging utilization volume assumption modified from 75% to 90% (\$800 million).
 - Statute of limitations for recouping overpayments increased from 3 to 5 years.
 - ACA unexpended co-op funds eliminated.
 - Fix did not include:
 - Elimination of increased Medicaid payment for primary care
 - Reductions in HOPD visit payments.
- Entitlement Reform is where medicine has the best chance of SGR repeal
 - CBO says repeal costs \$250 to \$300 billion.
 - Congress wants assurances that physicians are moving to more cost-effective payment and delivery systems.
 - AMA and 109 other medical societies signed a set of principles for replacing the SGR and moving into new delivery and payment models.
- AMA Draft Transition Plan
 - Step 1: Repeal the SGR; stabilize payments with at least two years of MEI updates for all. Bonus for infrastructure investments.
 - Step 2: CMS develops menu of Accountable Payment Models (APMs). APMs could be condition specific. Specialties could create and run models.
 - Step 3: CMS assigns one of three levels of points (low, medium or high) to physicians in each model. Participation is voluntary. Number of points is tied to Medicare dollars involved.
 - Step 4: In future years, Medicare updates are tied to the point system. Even those who aren't in one of the models would get at least a 0.5% update; others would get MEI or MEI plus a bonus. Physicians in a specialty without a CMS-approved model will get the full MEI update.
 - Step 5: CMS would provide an annual report on implementation and impact of the models and in the fifth year makes recommendations to Congress on whether to keep or modify the APM program.
 - This plan has been vetted with a task force of state and specialty medical representatives. Shared with state and specialty execs along with discussions with CMS and key Hill committee staff.

- The alternative is REAL SGR cuts. MedPAC, for example, has talked of just ratcheting up on cuts for physicians who don't go into an ACO.
- This model would allow physicians to participate in models that only hold them responsible for things they have control over.
- Other Congressional Issues
 - Gun Violence: AMA has lots of policy and will focus with help from APA on mental health.
 - Program Integrity: Expect more hearings on fraud and abuse.
 - Drug-related issues: compounding; prescription drug abuse and diversion. AMA promoting alternatives to mandatory CME and access restrictions.
 - IPAB Repeal: Bipartisan bill introduced earlier this week. AMA supports. Prospects of stand-alone bill in Senate aren't good.
 - Work Force: GME is threatened with cuts at the same time others want to grow the physician work force.
- Regulatory Agenda
 - Meaningful Use: AMA and hospital groups have called for study of impact of current requirements prior to adding more.
 - ICD-10:
 - AMA continues to oppose adoption
 - Many specialties didn't sign our group letter and most other health care providers don't want further delays. We are preparing education materials to anticipate change if it does occur.
 - HIPPA: Broad and complicated final regulation just released. Extends privacy requirements to more entities. AMA is still analyzing it.
 - Sunshine Law: Final regulation is not out. AMA continues to argue that proposed rule goes beyond the law and is unreasonable. For example, we do not believe that Congress intended to make certified CME subject to reporting. We also want an ongoing process for physicians to access and correct manufacturers' reports.

IX. Relative Value Recommendations for CPT 2014:

Drainage of Abscess (Tab 4)

Zeke Silva, MD, (ACR); Sean Tutton, MD, (SIR); Michael Hall, MD (SIR); Robert Vogelzang, MD, (SIR); Jerry Niedzwiecki, MD, (SIR)
Facilitation Committee #1

In January 2012, several codes describing the percutaneous drainage of abscesses were identified in the Codes reported together 75% or more screen, including 49021 *Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*, 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous*, and 49061 *Drainage of retroperitoneal abscess; percutaneous* along with CPT code 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*. In October 2012, the CPT Editorial Panel deleted nine codes and established four bundled codes to describe percutaneous image guided drainage of abscesses.

100XX1 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); soft tissue (eg, extremity, abdominal wall, neck), percutaneous

The RUC reviewed the survey results from 65 radiologists and determined that a work RVU of 3.00, the survey 25th percentile appropriately accounts for the physician work required to perform this service. The committee reviewed CPT code 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU=2.00) and determined that physician time and work of 100XX1 was greater. The RUC also reviewed 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* (work RVU=3.00) and determined that physician time and intensity were identical, and therefore, these two services should be valued the same. For additional support, the committee reviewed CPT codes 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU=3.12) and agreed that these services were similar in physician work and intensity. In addition, the RUC reviewed 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 MPC 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and agreed that 100XX1 required more physician work and complexity. **The RUC recommends a work RVU of 3.00, the survey 25th percentile for CPT code 100XX1.**

4900X2 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous

The RUC reviewed the survey results from 53 radiologists and determined that a work RVU of 4.25, the survey 25th percentile appropriately accounts for the physician work and time required to perform this service. The committee noted that this service was previously reported using a combination of the following deleted CPT codes: 32201 *Pneumonostomy; with percutaneous drainage of abscess or cyst* (work RVU=3.99), 47011 *Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages* (work RVU=3.69), 48511 *External drainage, pseudocyst of pancreas; percutaneous* (work RVU=3.99), and 50021 *Drainage of perirenal or renal abscess; percutaneous* (work RVU=3.37), along with 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation* (work RVU=1.19). The proposed work RVU of 4.25 is much lower than the previous work RVUs. In addition, the committee noted that patients described by 4900X2, 4900X3 and 4900X4 are sicker and more complex patients with deep abscesses. The committee reviewed CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU=4.21) and MPC codes 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU=4.10) and 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work

RVU=4.58) and determined that physician work and intensity are similar. **The RUC recommends a work RVU of 4.25, the survey 25th percentile for CPT code 4900X2.**

4900X3 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous

The RUC reviewed the survey results from 54 radiologists and determined that a work RVU of 4.25, which is slightly below the survey 25th percentile appropriately accounts for the physician work and time required to perform this service. The specialty societies confirmed that the physician work and time of 4900X2 and 4900X3 is identical and therefore the work RVU should be identical. The committee noted that this service was previously reported using a combination of 49021 *Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous* (work RVU=3.37), 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (work RVU=3.99) and 49061 *Drainage of retroperitoneal abscess; percutaneous* (work RVU=3.69) along with 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation* (work RVU=1.19). The proposed work RVU of 4.25 is much lower than the previous work RVUs. In addition, the committee noted that patients described by 4900X2, 4900X3 and 4900X4 are sicker and more complex patients with deep abscesses. The committee reviewed CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU=4.21) and MPC codes 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU=4.10) and 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU=4.58) and determined that physician work and intensity are similar. **The RUC recommends a work RVU of 4.25 for CPT code 4900X3.**

4900X4 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal

The RUC reviewed the survey results from 51 radiologists and determined that a work RVU of 4.50, the survey 25th percentile appropriately accounts for the physician work and time required to perform this service. There was consensus among the members that this procedure should be valued higher due to the complexity and intensity of transrectal and transvaginal abscesses. The committee noted that this service was previously reported by 58823 *Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)* (Work RVU=3.37), along with 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation* (work RVU=1.19). In addition, the committee noted that patients described by 4900X2, 4900X3 and 4900X4 are sicker and more complex patients with deep abscesses. The committee reviewed CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation,*

*management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous (work RVU=4.21) and MPC codes 11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less (work RVU=4.10) and 15004 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children (work RVU=4.58) and determined that physician work and intensity are similar. **The RUC recommends a work RVU of 4.50 for CPT code 4900X4.***

Practice Expense:

The practice expense (PE) standard for monitoring after moderate sedation is 15 minutes of RN time per 1 hour of monitoring. The specialty societies' recommendation of 60 minutes for this clinical staff activity indicates 4 hours of monitoring. The PE subcommittee determined that 4 hours of monitoring was not appropriate and that the typical time for recovery after moderate sedation for these services is 2 hours. The PE spreadsheet now reflects 30 minutes of RN time for 2 hours of monitoring. The RUC accepted the direct PE inputs for all codes with minor modifications as recommended by the PE Subcommittee.

Work Neutrality

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

Breast Biopsy (Tab 5)

Zeke Silva, MD, (ACR)

The specialty societies requested and the RUC agreed to postpone review of this issue until the April 2013 RUC meeting, after a valid number of survey responses are obtained.

Shoulder Prosthesis Removal (Tab 6)

William Creevy, MD, (AAOS); John Heiner, MD, (AAOS); Anne Miller, MD, (ASSH)

Doctor Daniel Nagle recused himself from voting on this issue

At the April 2012 meeting, the RUC referred CPT codes 23331 *Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)* and 23332 *Removal of foreign body, shoulder; complicated (eg, total shoulder)* to the CPT Editorial Panel to clearly distinguish between removal of prosthesis and other types of foreign bodies. At the October 2012 CPT meeting, the Editorial Panel approved three new codes, 2333X1 *Removal of foreign body, shoulder; deep (subfascial or intramuscular)*, 23333X *Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component* and 23334X *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid component(s) (eg, total shoulder)* to delineate between removal of foreign body and prosthesis.

Prior to valuing these procedures, the specialty societies presented compelling evidence to justify a change in the physician work value. The physician work and time components

of CPT codes 23331 and 23332 were based on the Harvard studies. Since that time, the technique and technology has changed. In the past, humeral prostheses were straight and smooth and the humeral side was typically not cemented, therefore, more easily removed. Cementing techniques, which previously were hand mixed and finger packed, have changed and are now pressurized and vacuum mixed and include the use of devices, such as a centrifuge and distal restrictor. The new technique has made removal more difficult. For components that are not cemented, current design includes metaphyseal fill, which is difficult to remove. Porous coated bone in growth also makes removal difficult since the bone has attached to the stem. In addition, polyethylene wear with resultant osteolysis and bone loss makes prosthesis and cement removal more complicated due to the increased risk of fracture and/or bone attached to the prosthesis. In order to avoid bone loss or fracture, and allow complete removal of cement to avoid infection, specialized equipment such as special osteotomes, high-speed surgical drill and ultrasound are utilized. Given this information, the RUC accepted compelling evidence that the current work RVU of 7.63 for 23331 and 12.37 for 23332 are potentially misvalued.

2333X1 Removal of foreign body, shoulder; deep (subfascial or intramuscular)

The RUC reviewed the survey results from 33 orthopedic and hand surgeons and recommended the following physician time components: pre-service time of 60 minutes, intra-service time of 45 minutes and post-service time of 15 minutes. The RUC agreed that 9 minutes of additional pre-service positioning time from the standard pre-service package is warranted to place the patient in the lateral beach chair position.

After review of physician time, the RUC determined that a work RVU of 6.00, the survey 25th percentile, is appropriate. The RUC reviewed the key reference service, 20680 *Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)* (work RVU=5.96) and determined that 2333X1 was more complex and requires more time. The RUC also reviewed CPT codes 25248 *Exploration with removal of deep foreign body, forearm or wrist* (work RVU=5.31) and 27372 *Removal of foreign body, deep, thigh region or knee area* and agreed that the physician work and complexity of 2333X1 was greater and therefore should be valued higher. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that one half discharge day, 99238, and two office visits, (1) 99212 and (1) 99213 were appropriate. The RUC agreed with the specialty societies that a level three office visit is necessary following this procedure to account for moderate to high complexity of medical decision making relating to wound care, suture removal, pain medication management, assessment of shoulder, elbow and hand function and coordination of rehabilitation. To support the number and level of post-operative visits, the RUC reviewed CPT code 23071 *Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater* (work RVU=5.91) which includes identical post-operative visits, and agreed that 2333X1 is a more complex procedure. **The RUC recommends a work RVU of 6.00 for CPT code 2333X1.**

23333X Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component

The RUC reviewed survey results from 31 orthopedic and hand surgeons and determined that the survey respondents overestimated the work value at the median level (work RVU= 20.00). To determine an appropriate value, the RUC agreed that a work RVU of 18.89, a direct crosswalk to CPT code 27269 *Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed* (work RVU=18.89), is appropriate. The time and intensity components of these two services are similar. In

addition, the RUC agreed that 12 minutes of additional pre-service positioning time from the standard pre-service package is warranted to either place the patient in the lateral beach chair position or on a radiolucent table for fluoroscopy. The RUC also reviewed CPT code 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU=22.00) and determined that this code should be valued slightly higher due to the physician work and complexity. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two level two hospital visits (99232), one discharge day(99238) and four office visits, (1) 99212 and (3) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later on the same day of surgery to evaluate wound, complete neuromuscular exam and monitor any potential respiratory issues. The RUC noted that the typical patient is older and presents with an infection, elevated white blood count and inflammatory markers. The surgeon is typically involved in intensive care coordination including managing PICC line and antibiotics with an infectious disease specialist, which can span 4-6 weeks and coordinating physical and occupational therapy. In addition, a musculoskeletal exam on the entire extremity as well as a neurovascular exam will be completed. Even though the procedure is for the upper extremity, determining gait pattern for these patients is essential because the extremity will be considered non-weight bearing post-surgery and will affect the patient's gait and balance. **The RUC recommends a work RVU of 18.89 for CPT code 23333X.**

23334X Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid component(s) (eg, total shoulder)

The RUC reviewed the survey results from 32 orthopedic and hand surgeons and determined that a work RVU of 22.13, a direct crosswalk to CPT code 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU=22.13) is appropriate. The intra service and total times are identical for these two services and thus substantiates an identical work RVU for both. In addition, the RUC agreed that 12 minutes of additional pre-service positioning time from the standard pre-service package is warranted to either place the patient in the lateral beach chair position or on a radiolucent table for fluoroscopy. The RUC also reviewed MPC code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU=19.68) and agreed that 23334X requires more physician work and complexity, and therefore, should be valued higher. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two level two hospital visits(99232) one discharge day (99238) and four office visits, (1) 99212 and (3) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an E/M service later on the same day of surgery to evaluate wound, complete neuromuscular exam and monitor any potential respiratory issues. The typical patient is older and presents with pain and decreased motion. Although, white blood count is normal, inflammatory markers are elevated. The surgeon is typically involved in intensive care coordination including managing antibiotics and coordinating physical and occupational therapy. In addition, a musculoskeletal exam on the entire extremity and neurovascular exam will be completed as well as assessing motor function determining restrictions since the entire extremity will be considered non-weight bearing post-surgery. Even though the procedure is for the upper extremity, determining gait pattern for these patients is essential because the extremity will be considered non-weight bearing post-surgery and

will affect the patient's gait and balance. **The RUC recommends a work RVU of 22.13 for CPT code 23334X.**

Elbow Prosthesis Removal (Tab 7)

William Creevy, MD, (AAOS); John Heiner, MD, (AAOS); Anne Miller, MD, (ASSH)

Doctor Daniel Nagle recused himself from voting on this issue

In April 2012, the RUC referred CPT Code 24160 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components* to the CPT Editorial Panel to revise the descriptor to clearly indicate "prosthetic removal". At the October 2012 CPT meeting, the Editorial Panel revised the code descriptor for 24160 and 24164 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar component; radial head* to describe "prosthesis" versus "implant".

Prior to valuing these procedures, the specialty societies presented compelling evidence to justify a change in the physician work value. The physician work and time components of CPT codes 24160 and 24164 were valued in the Harvard studies. Since that time, the technique and technology has changed. In the past, humeral prostheses were straight and smooth and the humeral side was typically not cemented, therefore, more easily removed. Cementing techniques have changed and are now pressurized and vacuum mixed and include the use of devices, such as a centrifuge and distal restrictor as opposed to hand mixed and finger packed. The new technique has made removal more difficult. For components that are not cemented, current design which includes metaphyseal fill, porous coated bone ingrowth also makes removal difficult since the bone has attached to the stem. In addition, polyethylene wear with resultant osteolysis and bone loss makes prosthesis and cement removal more complicated due to the increased risk of fracture and/or bone attached to the prosthesis. In order to avoid bone loss or fracture and allow complete removal of cement to avoid infection, specialized equipment such as special osteotomes, high-speed surgical drill and ultrasound are utilized. In addition, older versions of radial head implants were typically silastic and a single unit with a tapered stem. The flexible prosthesis made removal from the lateral elbow fairly straightforward. Current radial head prostheses are modular titanium implants with longer, wider and cylindrical stems. They are not flexible, thus, removal is a more difficult, complex and longer procedure. Additional soft tissue release is necessary to permit subluxation of the radius relative to the capitellum to allow extraction of the implant. The capsule and tendon insertion are then repaired back to the bone. Given this information, the RUC accepted compelling evidence that the current work RVU of 8.00 for 24160 and 6.43 for 24164 are potentially misvalued.

24160 Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components

The RUC reviewed survey results from 30 orthopedic and hand surgeons and the recommended the following physician time components: pre-service time of 72 minutes, intra-service time of 120 minutes and immediate post-service time of 30 minutes. The RUC agreed that 9 minutes of additional pre-service positioning time is warranted to either place the patient in the lateral decubitus position.

After review of the physician time, the RUC determined that a value of 18.63, the survey 25th percentile is appropriate. The RUC compared 24160 to key reference service 24363

Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) (work RVU=22.00) and determined that the reference code has an additional 40 minutes of total time, justifying the higher work RVU. The RUC also reviewed CPT codes 21242 *Arthroplasty, temporomandibular joint, with allograft* (work RVU=14.59), 24077 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm* (work RUV=15.72) and 23466 *Capsulorrhaphy, glenohumeral joint, any type multi-directional instability* (work RVU=15.80) and determined that 24160 is a more complex procedure. The typical patient is older and presents with pain and infection, typically resulting in cement removal and joint debridement. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two hospital visits, (1) 99231 and (1)99232, one discharge day (99238) and four office visits, (1) 99212 and (3) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later on the same day of surgery to evaluate wound, complete neuromuscular exam and monitor any potential respiratory issues. The RUC noted that the typical patient is older and presents with pain, decreased motion and wound drainage. The surgeon is typically involved in intensive care coordination with the primary care provider and relating to physical and occupational therapy. In addition, the physician will complete a musculoskeletal exam on the entire extremity as well as a neurovascular exam. Even though the procedure is for the upper extremity, determining gait pattern for these patients is essential because the extremity will be considered non-weight bearing post-surgery and will affect the patient's gait and balance. **The RUC recommends a work RVU of 18.63 for CPT code 24160.**

24164 Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar component; radial head

The RUC reviewed the survey results from orthopedic and hand surgeons and recommended the following physician time components: pre-service time of 60 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. The RUC agreed that 9 minutes of additional pre-service positioning time is warranted to either place the patient in the lateral decubitus position.

After review of the physician time, the RUC determined that a work RVU of 10.00, the survey 25th percentile, is appropriate. The RUC noted that this is a low volume procedure with 89 claims reported in 2011, which explains the low survey response. The RUC compared 24164 to key reference service 23430 *Tenodesis of long tendon of biceps* (work RVU=10.17) and determined that these two services should be valued similarly since the intra service time is the same with similar complexity. The RUC also reviewed MPC 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* (work RVU=11.19) and agreed that since this procedure requires more total time and complexity, it should be valued higher. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that one half of a discharge day (99238) and three office visits (99213) were appropriate. The surgeon is typically involved in intensive care coordination with the primary care provider and relating to physical and occupational therapy. In addition, the physician will complete a musculoskeletal exam on the entire extremity as well as a neurovascular exam. Even though the procedure is for the upper extremity, determining gait pattern for these patients is essential because the extremity will be considered non-weight bearing post-surgery and will affect the patient's gait and balance. . The RUC also agreed that 9 minutes of additional pre-service positioning time is warranted to either place the patient

in the lateral decubitus position. **The RUC recommends a work RVU of 10.00 for CPT code 24164.**

Esophagoscopy Gastroscopy Duodenoscopy (EGD) (Tab 8)

**Joel Brill MD, (AGA); Nickl, Bentley, MD, (ASGE); Donald Selzer, MD, (SAGES)
Facilitation Committee #3**

Several Esophagogastroduodenoscopy (EGD) codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were necessary to describe current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set.

Prior to valuing this series of EGD codes, the RUC discussed the difference in survey methodologies between this series and the previously RUC recommended series of esophagoscopy codes in October 2012. The esophagoscopy codes surveyed for the October 2012 RUC meeting were conducted under a mini-survey format in which only the base code 43200 was fully surveyed and the rest of the family was only surveyed for the work value and intra-service time. Given that only one survey existed for pre and post-service times, this resulted in standardized time components. Following the October 2012 meeting, the specialty societies requested and received approval from the Research Subcommittee to fully survey all elements of the codes moving forward. The RUC agreed with the specialty societies that in order to accurately value each procedure, the surveyed times should be used rather than arbitrarily deriving times from a previous survey.

To remain consistent relativity with this family of services and the esophagoscopy services, the RUC and specialty societies maintained a standardized set of methodologies to arrive at appropriate work values. The RUC administered three primary methodologies to value these services:

1. If a corresponding esophagoscopy code exists, and the previously billed codes are in the same endoscopic family, the Committee applied the Endoscopy Rule incremental approach.
2. If a corresponding esophagoscopy code exists and the additional codes were part of a different family of endoscopic procedure, the Committee applied the appropriate multiple procedure reduction.
3. If a corresponding esophagoscopy code did NOT exist, either the current value or the survey 25th percentile was recommended, whichever was lower.

43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed

The RUC reviewed the survey results from 315 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 15 minutes and post-service time= 12 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the survey's estimated work RVU and agreed that respondents overestimated the work value, with a 25th percentile (work RVU= 2.59) above the current value. Furthermore, the RUC noted that because the survey's median intra-service time is 5 minutes less compared to the current time, the current work RVU of 2.39 was also overvalued. To determine an appropriate work RVU, the RUC reviewed analogous CPT code 31579 *Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy* (work RVU= 2.26) and agreed that with identical intra-service time, 15 minutes, and similar total time, the two services should have identical work values. Therefore, 43235 should be valued at 2.26 work RVUs. To validate this RVU, the RUC reviewed MPC codes 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU= 2.29) and 52000 *Cystourethroscopy* (work RVU= 2.23) agreed that the services, with identical intra-service times, should all be valued similarly. **The RUC recommends a work RVU of 2.26 for CPT code 43235.**

43236 Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance

The RUC reviewed the survey results from 78 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. In addition, since the median intra-service time was less than the current time, the current value of 2.92 was deemed too high as well. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the submucosal injection code, 43201 (recommended work RVU= 1.90), should be maintained in this family of EGD services. Therefore, the established increment of 0.31 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.57 for 43236. To validate a work RVU of 2.57, the RUC compared the surveyed code to CPT code 32556 *Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance* (work RVU= 2.50) and agreed that with identical intra-service time, 20 minutes, and similar total time, the two services should be valued similarly. Code 43236 was also compared to MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and it was agreed that while both services have identical intra-service time, the reference code is slightly more intense and should therefore be valued higher. **The RUC recommends a work RVU of 2.57 for CPT code 43236.**

43239 Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple

The RUC reviewed the survey results from 310 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 15 minutes and post-service time= 12 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon that the current work RVU of 2.87 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the biopsy code, 43202 (recommended work RVU= 1.89), should be maintained in this family of EGD services. Therefore, the established increment of 0.30 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.56 for 43239. To validate a work RVU of 2.56, the RUC compared the surveyed code to MPC code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU= 2.50) and CPT code 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU= 2.58) and determined that with identical intra-service time, 15 minutes, the recommended work value is relative to other similar reference codes in the RBRVS. Finally, the RUC compared 43239 to 43236 and agreed that while the intra-service times are slightly different, the work values should be almost identical to maintain relativity within the family of EGD and esophagoscopy codes. **The RUC recommends a work RVU of 2.56 for CPT code 43239.**

43241 Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube, or catheter

The RUC reviewed the survey results from 39 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 33 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents greatly overestimated the value of this code, with a 25th percentile value of 3.50. The RUC noted that since there is no equivalent esophagoscopy code to compare, the current work RVU of 2.59 is appropriate. The RUC compared the surveyed code to CPT code 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service* (work RVU= 2.37) and agreed that while both codes have identical intra-service time, 30 minutes, and nearly identical total time, 43241 is a more intense procedure and should be valued slightly higher. Additionally, the RUC reviewed CPT code 57156 *Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy* (work RVU= 2.69) and agreed that since both this code and the surveyed code have identical intra-service time and comparable physician work, the recommended value for 43241 is appropriate. **The RUC recommends a work RVU of 2.59 for CPT code 43241.**

43243 Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices

The RUC reviewed the survey results from 58 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 4.56 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25th percentile work RVU of 4.37 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed since the two services have identical intra-service time, 30 minutes, both should be valued analogously. In addition, CPT code 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62, intra time= 30 minutes) was compared to 43243 and the RUC agreed that the reference code should be valued slightly higher than the surveyed code due to greater intensity and complexity. **The RUC recommends a work RVU of 4.37 for CPT code 43243.**

43244 *Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices*

The RUC reviewed the survey results from 69 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 5.04 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25th percentile work RVU of 4.50 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that while the two services have identical intra-service time, 30 minutes, 43244 should be valued higher as it is a more intense service. In addition, the RUC reviewed CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71) and noted that the two services, with identical intra-service time and analogous total time, should be valued similarly. Finally, the RUC compared 43244 to 43243 and agreed that while both codes have identical physician time, 43244 is a more intense procedure and is accurately valued slightly higher than 43243. **The RUC recommends a work RVU of 4.50 for CPT code 43244.**

43245 *Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)*

The RUC reviewed the survey results from 56 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 33 minutes, intra-service time= 23 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code, with a 25th percentile value of 3.58. The RUC noted that since there is no equivalent esophagoscopy code to

compare, the current work RVU of 3.18 is appropriate. The RUC compared the surveyed code to CPT code 58555 *Hysteroscopy, diagnostic* (work RVU= 3.33) and agreed that the reference code, with slightly greater intra-service time compared to the surveyed code, 25 minutes and 23 minutes, respectively, should be valued higher. Additionally, CPT code 43245 was compared to CPT code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU= 3.20) and it was agreed that while the surveyed code has two additional minutes of intra-service time, both services should be valued similarly. **The RUC recommends a work RVU of 3.18 for CPT code 43245.**

43247 Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body

The RUC reviewed the survey results from 68 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 23 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon that the current work RVU of 3.38 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the removal of foreign body code, 43215 (recommended work RVU= 2.60), should be maintained in this family of EGD services. Therefore, the established increment of 1.01 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.27 for 43247. To validate a work RVU of 3.27, the RUC compared the surveyed code to 36200 *Introduction of catheter, aorta* (work RVU= 3.02) and agreed that while both services have identical intra-service time, 30 minutes, the surveyed code should be valued higher due to greater intensity and complexity. Additionally, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and agreed that with identical times and analogous intensity, this reference code and 43247 should be valued similarly. **The RUC recommends and work RVU of 3.27 for CPT code 43247.**

43248 Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire

The RUC reviewed the survey results from 50 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 3.15 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the insertion of guide wire with dilation

code, 43226 (recommended work RVU= 2.34), should be maintained in this family of EGD services. Therefore, the established increment of 0.75 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.01 for 43248. To validate a work RVU of 3.01, the RUC compared the surveyed code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70) and agreed that while the two services have identical intra-service time, 20 minutes, the surveyed code should be valued higher, as it is a more intense procedure. In addition, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code has the same intra-service time as the surveyed code, the reference code has greater total time and should thus be valued higher. **The RUC recommends a work RVU of 3.01 for CPT code 43248.**

43249 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)

The RUC reviewed the survey results from 56 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 2.90 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the balloon dilation code, 43220 (recommended work RVU= 2.10), should be maintained in this family of EGD services. Therefore, the established increment of 0.51 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.77 for 43249. To validate a work RVU of 2.77, the RUC compared the surveyed code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70) and agreed that with identical intra-service time, 20 minutes, and analogous intensity and complexity, the two services should be valued similarly. In addition, the RUC also reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code and the surveyed code have identical intra-service time, the reference code has greater total time, 83 minutes compared to 62 minutes, and should be valued higher. Finally, the RUC compared this service to 43248 and noted that while both services have identical physician time components, 43249 is appropriately valued lower than 43248, as it is a less intense procedure. **The RUC recommends a work RVU of 2.77 for CPT code 43249.**

43250 Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

The RUC reviewed the survey results from 59 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 24 minutes, intra-service time= 20 minutes and post-service time= 14 minutes. The RUC agreed that two additional minutes of pre-service time above the

standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 3.20 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the removal of tumor by biopsy forceps code, 43216 (recommended work RVU= 2.40), should be maintained in this family of EGD services. Therefore, the established increment of 0.81 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.07 for 43250. To validate a work RVU of 3.07, the RUC compared the surveyed code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70) and agreed that while the two service have identical intra-service time, 20 minutes, the surveyed code should be valued higher, as it is a more intense procedure. In addition, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code has the same intra-service time as the surveyed code, the reference code has greater total time and should thus be valued higher. Finally, the RUC reviewed 43250 in comparison to 43248 and 43249 and agreed that all three codes have identical intra-service time and are appropriately valued similarly. **The RUC recommends a work RVU of 3.07 for CPT code 43250.**

43252 Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy

The RUC reviewed the survey results from 26 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, the RUC compared this new service to the newly created esophagoscopy optical endomicroscopy code 4321X1. To ensure consistency, the RUC maintained the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the optical endomicroscopy code, 4321X1 (recommended work RVU= 2.39). Therefore, the established increment of 0.80 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.07 for 43250. To validate a work RVU of 3.06, the RUC compared the surveyed code to 36200 *Introduction of catheter, aorta* (work RVU= 3.02) and agreed that since both codes have identical intra-service time, 30 minutes, and comparable physician work, the two services should be valued similarly. In addition, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and noted that while the two services have identical intra-service time, the reference code has greater total time compared to the surveyed code, 90 minutes and 77 minutes, respectively. Therefore, the 43252 is appropriately valued less than 50386. **The RUC recommends and work RVU of 3.06 for CPT code 43252.**

43255 Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method

The RUC reviewed the survey results from 82 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 4.81 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25th percentile work RVU of 4.20 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that since both codes have identical intra-service time (30 minutes), and analogous total time, the two services should be valued similarly. Additionally, the RUC reviewed CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71) and noted that while the reference code has identical intra-service time compared to 43255, 37191 should be valued greater because it is a more intense and complex service. **The RUC recommends a work RVU of 4.20 for CPT code 43255.**

43257 Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease

The RUC reviewed the survey results from 25 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 5.50 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25th percentile work RVU of 4.25 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 31648 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe* (work RVU= 4.20) and agreed that since both services have identical intra-service time, 45 minutes, and analogous intensity, they should both be valued similarly. The RUC also reviewed CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and noted that while both services have identical intra-service time, the reference code has much greater total time compared to the surveyed code and should thus be valued higher. **The RUC recommends a work RVU of 4.25 for CPT code 43257.**

4325X4 Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection

The RUC reviewed the survey results from 43 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey and agreed with the specialty societies that the 25th percentile work RVU of 5.25 accurately values this service. To validate this work value, the RUC noted that this service contains three additional services from the base code: removal of lesion by snare, band ligation, and submucosal injection. The consistent increment approach was applied to sum the incremental differences between the equivalent esophagoscopy codes and the base code, 43200 (recommended work RVU= 1.59): 43217 (recommended work RVU= 2.90), increment difference= 1.31; 43205 (recommended work RVU= 3.00), incremental difference= 1.41; and 43201 (recommended work RVU= 1.90), incremental difference= 0.31). Adding the work RVU differences, 3.03, to the base EGD code 43235 (recommended work RVU= 2.26) arrives at a work RVU of 5.29, slightly higher than the recommended work value of 5.25. The RUC compared the surveyed code to CPT code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated* (work RVU= 5.20) and agreed that since these two codes have identical intra-service time, 45 minutes, and comparable physician work, they should be valued similarly. Finally, the RUC reviewed CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU= 5.35) and noted that while both services have identical intra-service time, the reference code has greater total time compared to 4325X4, 116 minutes and 103 minutes, respectively. Therefore, the reference code is accurately valued higher than the surveyed code. **The RUC recommends a work RVU of 5.25 for CPT code 4325X4.**

4326X7 Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)

The RUC reviewed the survey results from 35 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25th percentile work RVU of 4.45 accurately values this service. To validate this work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and noted that while both codes have identical intra-service time, 30 minutes, the surveyed code should be valued higher because it is a more intense and complex to

perform. The RUC also reviewed CPT code 93452 *Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU= 4.75) and agreed that since the reference code has greater total time compared to 4326X7, 108 minutes and 88 minutes, respectively, it is appropriately valued higher. **The RUC recommends a work RVU of 4.45 for CPT code 4326X7.**

4326X8 Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

The RUC reviewed the survey results from 51 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 40 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25th percentile work RVU of 4.40 accurately values this service. To validate this work value, the RUC compared the surveyed code to CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU= 4.21) and noted that since both codes have identical intra-service time, 40 minutes, and analogous physician work, the two services should be valued similarly. The RUC also reviewed CPT code 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74) and agreed that the reference code should be valued higher since it is a more intense procedure than 4326X8. Finally, the RUC compared 4326X8 to 4326X7 (recommended work RVU= 4.45) and agreed that while 4326X8 has 10 minutes more intra-service time, placement of an endoscopic stent is a more intense procedure than balloon dilation of the esophagus and, therefore, both services should be valued similarly. **The RUC recommends a work RVU of 4.40 for CPT code 4326X8.**

4326X9 Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

The RUC reviewed the survey results from 49 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25th percentile work RVU of 4.39 accurately values this service. To validate this work value, the RUC compared the surveyed code to CPT code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10) and agreed that while both codes have identical intra-service time, 45 minutes, 4326X9 is a more intense and complex service and should be valued higher than the reference code. The

RUC also reviewed CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and noted that with greater total time compared to the surveyed code, 123 minutes and 101 minutes, respectively, the reference code is accurately valued higher than 4326X9. **The RUC recommends a work RVU of 4.39 for CPT code 4326X9.**

43246 Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube

The RUC reviewed the survey data for 43246 and agreed with the specialty societies that a median intra-service time of 23 minutes grossly underestimates the time it takes to perform this procedure. An eight minute time differential between the base code, 15 minutes, and this code, 23 minutes, does not accurately account for the additional work in placing the percutaneous gastrostomy tube. **Therefore, the RUC recommends that CPT code 43246 be re-surveyed for presentation at the April 2013 RUC meeting.**

43251 Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

The RUC reviewed the survey data for 43251 and agreed with the specialty societies that a median intra-service time of 20 minutes grossly underestimates the time it takes to perform this procedure. A five minute time differential between the base code, 15 minutes, and this code, 20 minutes, does not accurately account for the additional work in removing a lesion by snare technique. Additionally, the esophagoscopy equivalent codes had a time differential of 15 minutes. **Therefore, the RUC recommends that CPT code 43251 be re-surveyed for presentation at the April 2013 RUC meeting.**

CPT Editorial Panel Referral:

In the Panel Action memo from the October CPT Editorial Panel meeting CPT requested clarifications from the involved specialty societies regarding instructions affecting the EGD codes (43235-43259). A specific request was made for the societies to provide clarification regarding the reporting of reduced service modifiers and an EGD service. After discussions with CPT and RUC staff it was determined that the CPT Editorial Panel's request for clarification will require a material change to codes 43237 and 43238 requiring approval by the CPT Editorial Panel. Therefore, the RUC approved the specialty societies' request to refer these services back to CPT and survey these services for presentation at the April 2013 RUC meeting.

Practice Expense:

The practice expense for these services was a direct crosswalk to the approved practice expense for the related esophagoscopy codes approved at the October 2012 RUC meeting. At the January 2013 RUC meeting the Practice Expense Subcommittee recommended and the RUC approved the following changes to the practice expense for esophagogastroduodenoscopy and the specialty requests that the changes be applied to the esophagoscopy codes that were previously approved at the October 2012 RUC meeting.

- Addition of 3 minutes to "Prepare room, equipment, supplies" (L037D) for code 43252 (*Esophagogastroduodenoscopy; with optical endomicroscopy*) for the technician to turn on the optical endomicroscope processor unit system added to its esophagoscopy counterpart, 43206 (*Esophagoscopy, flexible, transoral; with optical endomicroscopy*)
- At the last meeting the Practice Expense Subcommittee used equipment practice expense input EQ322 *Radiofrequency generator (Angiodynamics), liver RFA* as a proxy. The specialty will identify a more appropriate RF ablation system for

4326X9 (*Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)*) and provide an invoice for this equipment. It should also be added to its esophagoscopy counterpart 4320X5 (*Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)*) which replaced 43228

- Addition of “Instrument pack basic (\$500 - \$1,499)” (EQ137) for 43248 (*Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire*) added to its esophagoscopy counterpart 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire*)
 - Addition of “Pack, cleaning, surgical instruments” (SA043) for 43248 (*Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire*) for cleaning the dilators added to its counterpart 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire*)

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.

Esophagoscopy- January 2013 (Tab 9)

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Facilitation Committee #3

In September 2011, several esophagoscopy codes were identified through the CMS Multi-Specialty Points of Comparison (MPC) List screen as potentially misvalued. The specialties agreed to survey the entire family of codes (43200-43232). In developing vignettes, it was determined that the codes required revision at CPT to differentiate the approach (ie, rigid transoral, flexible transoral, flexible transnasal). In May 2012, the CPT Editorial Panel approved six new codes to report rigid transoral esophagoscopy (4319X1-X6), two new codes to report flexible transnasal esophagoscopy (4319X7-X8), revision to codes 43200-43232 to describe flexible transoral esophagoscopy and one new code for flexible transoral esophagoscopy (43206). In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with an additional five codes within the esophagoscopy family of services. These five codes were reviewed at the January 2013 RUC meeting.

4320X1 Esophagoscopy, flexible, transoral; with endoscopic mucosal resection

The RUC reviewed the survey results from 62 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 18 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25th percentile work RVU of 4.91. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 4320X1 should be valued less than the equivalent EGD code 4325X4 (recommended work RVU= 5.25). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 4325X4, for a recommended work RVU of 4.58. To validate a work RVU of 4.58, the RUC compared the surveyed code to CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and agreed that since both codes have identical intra-service time, 45 minutes, and analogous physician work, both codes should be valued identically. In addition, the RUC reviewed CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU= 5.35) and noted that while both codes have identical intra-service time, the reference code is a more intense procedure and has more total time than 4320X1. Therefore, the RUC agreed that the reference code should be valued higher. **The RUC recommends a work RVU of 4.58 for CPT code 4320X1.**

4320X2 Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)

The RUC reviewed the survey results from 45 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that since there is no equivalent esophagoscopy crosswalk to determine the incremental physician work, the survey's 25th percentile work RVU of 5.00 is appropriate. To validate this work value, the RUC compared the surveyed code to CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and agreed that while both services have identical intra-service time, 45 minutes, the surveyed code is a more intense procedure and should be valued slightly higher. The RUC also reviewed CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU= 5.35) and noted that this reference code has greater total time than the surveyed code, 116 minutes and 101 minutes, respectively. Therefore, 4320X2 is appropriately valued slightly less than 36251. **The RUC recommends a work RVU of 5.00 for CPT code 4320X2.**

4320X3 Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)

The RUC reviewed the survey results from 42 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 16 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25th percentile work RVU of 3.86. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 4320X3 should be valued less than the equivalent EGD code 4326X7 (recommended work RVU= 4.45). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 4326X7, for a recommended work RVU of 3.78. To validate a work RVU of 3.78, the RUC compared the surveyed code to 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and noted that while both codes have identical intra-service time, 30 minutes, 4320X3 should be valued higher due to greater intensity and complexity. In addition, the RUC reviewed CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that the reference code is a slightly more intense service compared to the surveyed code and is appropriately valued higher. **The RUC recommends a work RVU of 3.78 for CPT code 4320X3.**

4320X4 Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

The RUC reviewed the survey results from 53 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25th percentile work RVU of 4.36. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 4320X4 should be valued less than the equivalent EGD code 4326X8 (recommended work RVU= 4.40). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 4326X8, for a recommended work RVU of 3.73. To validate a work RVU of 3.73, the RUC compared the surveyed code to CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and noted that while both codes have identical intra-service time, 30 minutes, 4320X4 should be valued higher due to greater intensity and complexity. The RUC also reviewed CPT code 20660 *Application of cranial tongs, caliper, or stereotactic*

frame, including removal (separate procedure) (work RVU= 4.00) and noted that this reference code is more intense than 4320X4 and should be valued slightly higher. Finally, the RUC compared 4320X4 to 4320X3 and agreed that with almost identical physician time, the two services are correctly valued similarly. **The RUC recommends a work RVU of 3.73 for CPT code 4320X4.**

4320X5 Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

The RUC reviewed the survey results from 51 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 40 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25th percentile work RVU of 4.68. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 4320X5 should be valued less than the equivalent EGD code 4326X9 (recommended work RVU= 4.39). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 4326X9, for a recommended work RVU of 3.72. To validate a work RVU of 3.72, the RUC compared the surveyed code to CPT code 19105 *Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma* (work RVU= 3.69) and agreed that since both codes have 45 minutes of intra-service time and almost identical total time, the two services should be valued similarly. The RUC also reviewed 31626 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple* (work RVU= 4.16) and noted that the reference code is a more intense procedure and should be valued higher than 4320X5. Finally, the RUC compared 4320X5 to 4320X4 and 4320X3 and agreed that while 4320X5 has 15 minutes more intra-service time compared to these two codes, this surveyed code should be valued similarly as it is a less intense services comparably. **The RUC recommends a work RVU of 3.72 for CPT code 4320X5.**

Practice Expense:

At the January 2013 RUC meeting the practice expense for these services was a direct crosswalk to the approved practice expense for the related esophagoscopy codes approved at the October 2012 RUC meeting. At the January 2013 RUC meeting the Practice Expense Subcommittee recommended and the RUC approved the following changes to the practice expense for esophagogastroduodenoscopy and the specialty requests that the changes be applied to the esophagoscopy codes that were previously approved at the October 2012 RUC meeting.

- Addition of 3 minutes to “Prepare room, equipment, supplies” (L037D) for code 43252 (Esophagogastroduodenoscopy; with optical endomicroscopy) for the technician to turn on the optical endomicroscope processor unit system added to its esophagoscopy counterpart, 43206 (Esophagoscopy, flexible, transoral; with optical endomicroscopy)

- At the last meeting the Practice Expense Subcommittee used equipment practice expense input EQ322 Radiofrequency generator (Angiodynamics), liver RFA as a proxy. The specialty will identify a more appropriate RF ablation system for 4326X9 (Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)) and provide an invoice for this equipment. It should also be added to its esophagoscopy counterpart 4320X5 (Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)) which replaced 43228
- Addition of “Instrument pack basic (\$500 - \$1,499)” (EQ137) for 43248 (Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire) added to its esophagoscopy counterpart 43226 (Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire)
- Addition of “Pack, cleaning, surgical instruments” (SA043) for 43248 (Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire) for cleaning the dilators added to its counterpart 43226 (Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire)

Work Neutrality:

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

Chemodenervation of Extremity and Trunk Muscles (Tab 10)

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Facilitation Committee #1

In October 2012, the CPT Editorial Panel established six new codes and instructional guidelines to more accurately describe and report chemodenervation of extremity and trunk muscles.

646X1X Chemodenervation of one extremity; 1-4 muscle(s)

The RUC reviewed the survey results from 44 physicians for 646X1X and determined that the specialty recommended work RVU of 1.85 between the survey 25th percentile and median is not appropriate for this service. The Physician work times are 15 minutes pre-service, 20 minutes intra-service and 5 minutes post-service. The specialty recommended a work RVU of 1.85 based on a crosswalk to CPT code 64615 *Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)* (work RVU=1.85, and 15 minutes pre-service, 15 minutes intra-service, and 5 minutes immediate post-service) because 64615 has the same time, is part of the chemodenervation family and was valued in April of 2012, however this code is still a CMS interim value and involves 31 injections rather than the 8-10 that are typical in this service. The RUC determined that a work RVU of 1.65, the survey 25th percentile is appropriate. The RUC compared 646X1X to CPT codes 16025 *Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)* (work RVU = 1.74, 15 minutes pre-service, 20 minutes intra-service, 3 minutes

post-service) and 51784 *Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)* (work RVU = 1.53 and 10 minutes pre-service, 20 minutes intra-service, 10 minutes post-service) and agreed that the time and intensity components were similar. **The RUC recommends a work RVU of 1.65 for CPT code 646X1X.**

646X2X Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure)

The RUC approved an adjustment to the pre-service positioning time to include 1 minute. Although this is an add-on code there is positioning time associated with an additional extremity that was not accounted for in the specialty recommendation. The RUC reviewed the survey results from 44 physicians for 646X2X and determined that the specialty recommended work RVU of 1.43 is not appropriate for this service. The Physician work times are 1 minutes pre-service and 20 minutes intra-service. The RUC discussed the survey 25th percentile of 1.00, however this value does not account for the work of additional muscles associated with performing this service. The RUC determined that a direct crosswalk to CPT code 31633 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* (RVU = 1.32, 20 minutes intra-service) is appropriate for this service. The RUC noted that these two services have the same intra-service time. For additional support the RUC compared 646X2X to CPT code 49412 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)* (work RVU = 1.50, 20 minutes intra-service) and CPT code 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.03, 20 minutes intra-service) and determined that the time and complexity were similar. **The RUC recommends a work RVU of 1.32 for CPT code 646X2X.**

646X3X Chemodenervation of one extremity; 5 or more muscle(s)

The RUC reviewed the survey results from 44 physicians for 646X3X, and determined that, the specialty recommended work RVU of 2.20 between the survey 25th and median is not appropriate for this service. The Physician work times are 15 minutes pre-service, 25 minutes intra-service and 5 minutes post-service. The RUC determined that the survey 25th percentile work RVU of 1.82 is appropriate for this service relative to other similar services. The RUC compared 646X3X to CPT code 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, 11 minutes pre-service, 25 minutes intra-service and 5 minutes post-service) and CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU = 1.56, 15 minutes pre-service, 25 minutes intra-service, 10 minutes post-service) and determined that the time and complexity components were similar. **The RUC recommends a work RVU of 1.82 for CPT code 646X3X.**

646X4X Chemodenervation of one extremity; each additional extremity, 5 or more muscle(s) (List separately in addition to code for primary procedure)

The RUC approved an adjustment to the pre-service positioning time to include 1 minute. Although this is an add-on code there is positioning time associated with an additional extremity that was not accounted for in the specialty recommendation. The RUC also

approved an adjustment to the intra-service time to add 5 minutes to be consistent with the base code reported with the add-on code. The RUC reviewed the survey results from 43 physicians for 646X4X and determined that the specialty recommended work RVU of 1.70 is not appropriate for this service. The Physician times are 1 minute pre-service, and 25 minutes intra-service. There was consensus among the RUC that a work RVU of 1.20, the survey 25th percentile does not appropriately account for the work of additional extremities associated with performing this service. The RUC determined that the increment of 0.20, which corresponds with the increment between the survey 25th percentile of 646X2X and the survey 25th percentile of 646X4X, can be applied to this code to account for the intensity and work of additional extremities. The work RVU was determined by starting with the RUC recommended value of 646X2X, work RVU of 1.32 and adding the increment of 0.20 for a total work RVU of 1.52. For additional support, the RUC referenced codes 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, 11 minutes pre-service, 25 minutes intra-service and 5 minutes post-service) and CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU = 1.56, 15 minutes pre-service, 25 minutes intra-service and 10 minutes post-service). **The RUC recommends a work RVU of 1.52 for CPT code 646X4X.**

646X5X Chemodenervation of trunk muscle(s); 1-5 muscle(s)

The RUC reviewed the survey results from 32 physicians for 646X5X and determined that the specialty recommended work RVU of 1.80, the survey 25th percentile is appropriate for this service. The Physician times are 15 minutes pre-service, 20 minutes intra-service and 5 minutes post-service, The RUC compared 646X5X to CPT code 56820 *Colposcopy of the vulva;* (work RVU = 1.05, 15 minutes pre-service, 15 minutes intra-service, 10 minutes post-service) and CPT code 51784 *Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique* (work RVU = 1.53, 10 pre-service, 20 intra-service, 10 post-service) and determined that these services require similar physician work to perform. **The RUC recommends a work RVU of 1.80 for CPT code 646X5X.**

646X6X Chemodenervation of trunk muscle(s); 6 or more muscle(s)

The RUC reviewed the survey results from 31 physicians for 646X6X and approved times of 15 minutes pre-service, 25 minutes intra-service and 5 minutes post-service time. The RUC determined that the survey 25th percentile work RVU of 2.11 appropriately accounts for the physician work required to perform this service. The RUC compared 646X6X to CPT code 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, 11 minutes pre-service, 25 minutes intra-service and 5 minutes post-service) and CPT code 57460 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix* (work RVU = 2.83, 15 minutes pre-service, 25 minutes intra-service and 10 minutes post-service) and determined that the recommended work RVU of 2.11 is appropriate relative to other similar services. **The RUC recommends a work RVU of 2.11 for CPT code 646X6X.**

Practice Expense:

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

Work Neutrality:

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

Chemodenervation of Neck Muscles (Tab 11)

Kevin Kerber, MD, (AAN); Wayne Cornblath, MD, (AAN); Janice Massey, MD, (AANEM)

Facilitation Committee #1

In February 2012, the CPT Editorial Panel created one CPT code 64615 to describe a new injection paradigm for treatment of chronic migraine as current codes did not describe the totality of the work performed. In April 2012, the RUC reviewed the chemodenervation family of codes and 64613 was referred to the CPT Editorial panel to create two codes, one to describe chemodenervation for spasmodic torticollis and another to describe chemodenervation for spasmodic dysphonia. The panel determined that injecting the neck muscle versus injecting the larynx involves different levels of work and intensity and the code was divided into two separate codes.

64613X Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)

The RUC reviewed survey results from 80 neurologists and determined that the specialty recommended work RVU of 1.85 is not appropriate for this service. The specialty recommended this value based on a crosswalk to CPT code 64615 *Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)* (work RVU=1.85, 15 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service) because 64615 requires the same physician time, is part of the chemodenervation family and was recently valued in April of 2012. However, the work RVU for CPT code 64615 is currently considered an interim value by CMS and involves 31 injections rather than the 8-10 that are typically required for the surveyed service. The RUC noted that this service will primarily be reported by neurology. The RUC agreed with the specialty recommended pre-service package 5 (Procedure without sedation/anesthesia care), with the addition of 3 minutes of pre-service time for mixing the toxin. The Physician work times are 15 minutes pre-service, 15 minutes intra-service and 5 minutes post-service. The RUC determined that the survey 25th percentile work RVU of 1.79 is an appropriate value for this service. The RUC compared 64613X to similar services CPT code 53855 *Insertion of a temporary prostatic urethral stent, including urethral measurement* (work RVU = 1.64, 15 minutes intra-service time) and 64425 *Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves* (work RVU = 1.75, 15 minutes intra-service time) which both require the same intra-service physician work to perform. **The RUC recommends a work RVU of 1.79 and for CPT code 64613X.**

6461XX Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed

The RUC reviewed survey results from 60 Otolaryngologists that perform this service and determined that the specialty recommended work RVU of 2.19 is not appropriate for this service and that a work RVU of 2.06, a direct crosswalk to CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (RVU = 2.06, 15 minutes intra, 43 total) is appropriate for this service. CPT code 6461XX requires slightly less total time, but the same intra-service time and it is a more intense service to perform.

The RUC agreed that a work RVU of 1.82, the 25th percentile of the survey, does not appropriately account for the level of complexity and risk associated with this service. The RUC noted that this service will primarily be reported by otolaryngology. The RUC approved an adjustment to the intra-service time removing 5 minutes of scrub dress and wait time and adding 5 minutes to the intra-service time. Anesthesia related to this service is more appropriately placed in the intra-service time because the anesthesia is injected directly into the larynx, which can cause significant reaction. The physicians must stay at the bedside during this time. The RUC agreed with the specialty recommended pre-service package 6 (Procedure with sedation/anesthesia care), with an adjustment to the pre-service evaluation time of 2 minutes less resulting in 15 total minutes of pre-service evaluation time. The RUC recommends 16 minutes pre-service, 15 minutes intra-service and 5 minutes post-service time for a total time of 36 minutes. For additional support, the RUC compared 6461XX to MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina*; (work RVU = 1.50, 15 minutes pre-service, 15 minutes intra-service, 10 minutes post-service), which requires the same intra-service time, but is less intense to perform and MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU=2.23, 17 minutes pre-service, 15 minutes intra-service, 10 minutes post-service), which requires the same intra-service time but is more intense to perform. **The RUC recommends a work RVU of 2.06 for CPT code 6461XX.**

Practice Expense:

The RUC accepted the direct practice expense inputs for both codes with the appropriate adjustments to reflect altered intra-service time and equipment time for CPT code 6461XX.

Insertion of Anterior Segment Device (Tab 12)

Stephen A. Kamenetzky, MD, (AAO) and Mark Sherwood, MD, (AAO)

In October 2012, the CPT Editorial Panel approved to convert category III code, 0192T *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* to a category I code, 6618X1 due to widespread use and adequate published peer reviewed articles supporting the safety and effectiveness of the procedure.

In January 2013, the RUC reviewed the survey results for these services and determined that the post-operative visits may have been incorrectly calculated. The RUC recommended postponement of these services until the April 2013 RUC meeting to allow the specialty society sufficient time to ensure that the post-operative visits were appropriately estimated.

Practice Expense:

The RUC accepted the direct practice expense inputs with no modifications as approved by the Practice Expense Subcommittee.

Removal of Cerumen (Tab 13)

Wayne Koch, MD, (AAO-HNS); John Lanza, MD, (AAO-HNS) and Thomas Felger, MD, (AAFP)

This code was identified through the CMS High Expenditure Screen within the Proposed Rule for the 2012 Medicare Fee Schedule. In response, the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) submitted an action plan during

the January 2012 RUC meeting indicating they would perform a survey of CPT 69210 for the April 2012 RUC meeting. During its review of the action plan, the Relativity Assessment Workgroup (RAW) questioned whether the existing value for 69210 represented payment for the physician work for one or both ears and noted that the descriptor, in its current state, was unclear in this regard. The AAO-HNS responded to the RAW's concern by submitting a code change proposal (CCP) to the CPT Editorial Panel, for its October 2012 meeting, which revised the code to more accurately describe the removal of cerumen with instrumentation and to specify that it should be reported as unilateral. The revised CPT code 69210 was surveyed for the April 2013 RUC meeting.

69210 Removal impacted cerumen requiring instrumentation, unilateral

The RUC reviewed the survey data from 312 otolaryngologists and family physicians and recommends the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 2 minutes.

The RUC noted that this procedure was previously billed as either unilateral or bilateral and has now been revised to report only unilateral. Therefore, since there is no compelling evidence that this procedure is currently misvalued, the RUC recommends applying work neutrality to CPT code 69210. To determine work neutrality, the specialty society discussed that it is anticipated that 10% of the current utilization is billed as bilateral. Given these assumptions, the RUC recommends a work neutral work RVU of 0.58. To validate this value, the RUC compared the surveyed code to CPT code 11000 *Debridement of extensive eczematous or infected skin; up to 10% of body surface* (work RVU= 0.60) and agreed that both codes have identical intra-service time, 10 minutes, and comparable physician work; therefore, the two codes should be valued similarly. The RUC also reviewed CPT code 29580 *Strapping; Unna boot* (work RVU= 0.55) and noted that, while the reference code has two additional minutes of intra-service time compared to the surveyed code, the two codes should be valued similarly since 69210 is a slightly more intense procedure. **The RUC recommends a work RVU of 0.58 for CPT code 69210.**

Practice Expense:

The RUC reviewed and accepted the modifications to the equipment, which were deemed indirect, as recommended by the Practice Expense Subcommittee.

Work Neutrality:

Under current reporting, CPT code 69210 cannot be billed with the bilateral modifier (52). Therefore, there is no available claims data to substantiate accurate reporting. The RUC will review one year of Medicare claims data, once available, to determine if the 10% bilateral usage assumption is accurate.

Respiratory Motion Management Simulation (Tab 14)

Najeeb Mohideen, MD, (ASTRO); Micheal Kuettel, MD, PhD, (ASTRO); Dwight Heron, MD, (ASTRO); and Gerald White, MS (ASTRO)

Facilitation Committee #2

These services were identified as part of two CMS screens, the Harvard Valued - Utilization over 30,000 CMS screen as well as the Services with Stand-Alone PE Procedure Time screen. In September 2011, the RUC recommended that the specialty societies survey work and review PE for January 2012. In January 2012 the specialties requested referral to the CPT Editorial Panel and in October 2012 the panel revised CPT

codes 77280, 77285, 77290 and 77295 to more accurately describe radiotherapy simulation and established an add-on code to describe respiratory motion management simulation.

77280 Therapeutic radiology simulation-aided field setting; simple

The RUC reviewed the survey results from 74 radiation oncologists for CPT code 77280 and recognized that there is a technical component performed by a radiation therapist concurrently with the physician work. The RUC determined that the specialty recommended current work RVU of 0.70 is appropriate for this service. The RUC recommends 7 minutes pre-service, 25 minutes intra-service and 5 minutes post-service. The RUC compared 77280 to similar service 77300 *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician* (work RVU=0.62, 15 minutes intra-service) and noted that 77280 requires more time to perform, accounting for the higher work value. For additional support, the RUC compared 77280 to CPT code 92579 *Visual reinforcement audiometry (VRA)* (work RVU=0.70, 4 minutes pre-service, 25 minutes intra-service and 5 minutes post-service), and noted that both codes have the same work value and the same intra-service time. **The RUC recommends a work RVU of 0.70 for CPT code 77280.**

77285 Therapeutic radiology simulation-aided field setting; intermediate

The RUC reviewed the survey results from 57 radiation oncologists for CPT code 77285 and recognized that there is a technical component performed by a radiation therapist concurrently with the physician work. The RUC determined that the specialty recommended current work RVU of 1.05 is appropriate for this service. The RUC recommends 7 minutes pre-service, 40 minutes intra-service and 5 minutes post-service. The RUC compared 77285 to similar service 77331 *Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician* (work RVU=0.87, 30 minutes intra-service) and noted that 77285 requires more time to perform, accounting for the higher work value. For additional support, the RUC compared 77285 to CPT code 88361 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology* (work RVU=1.18, 40 minutes intra-service), and noted that the codes have the same intra-service time, but 88361 is more intense to perform, accounting for the higher work value. **The RUC recommends a work RVU of 1.05 for CPT code 77285.**

77290 Therapeutic radiology simulation-aided field setting; complex

The RUC reviewed the survey results from 66 radiation oncologists for CPT code 77290 and discussed that there is a technical component performed by a radiation therapist concurrently with the physician work. The RUC determined that the specialty recommended current work RVU of 1.56 is appropriate for this service. The RUC recommends 7 minutes pre-service, 60 minutes intra-service and 10 minutes post-service. The RUC questioned the additional 5 minutes of post-service in relation to 77285, when the work appears to be identical. The specialty clarified that there are 4 separate fields for the complex service, which all have to be recorded, requiring more time than the intermediate code. The RUC compared 77280 to similar service 77315 *Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)* (work RVU=1.56, 45 minutes intra-service), with identical work values.

For additional support, the RUC compared 77290 to CPT code 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU=1.63, 50 minutes intra-service), and noted that 88321 requires less time, but is more intense to perform, accounting for the higher work value. **The RUC recommends a work RVU of 1.56 for CPT code 77290.**

772X1X Respiratory motion management simulation

The RUC reviewed the survey results from 49 radiation oncologists for CPT code new add-on CPT code 772X1X and discussed the division of work between the medical physicist and the physicians. The specialty clarified that there is a large amount of patient training that the physician must perform for this service. The medical physicist will not be able to provide this training as it is the physician who will determine the physical limitations of the patient. The RUC determined that the survey 25th percentile work RVU of 2.00 and 45 minutes intra-service time are appropriate for this service. The RUC compared 772X1X to similar service 77470 *Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)* (work RVU=2.09, 55 minutes intra-service) and noted that 77470 requires more time to perform accounting for the higher work value. For additional support, the RUC compared 772X1X to CPT code 48400 *Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)* (work RVU=1.95, 45 minutes intra-service), and noted that both services have identical intra-service time and 772X1X is slightly more intense to perform, accounting for the higher work value. **The RUC recommends a work RVU of 2.00 for CPT code 772X1X.**

77295 Therapeutic radiology simulation-aided field setting; 3-dimensional

The RUC reviewed the survey results from 67 radiation oncologists for CPT code 77295 and determined that the specialty recommended current work RVU of 4.56 was not appropriate for this service. The RUC recommends 7 minutes pre-service, 90 minutes intra-service and 15 minutes post-service. The RUC compared 77295 to 77338 *Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan* (work RVU = 4.29, 0 minutes pre-service, 115 minutes intra-service and 0 minutes post-service), which requires the same physician work to perform. The code is also in a similar family of codes and both are radiation treatment dosimetry. The RUC determined that 77338 is an appropriate crosswalk and determined that a work RVU of 4.29 appropriately accounts the physician work required to perform 77295. For additional support, the RUC compared 77295 to similar services 77787 *Remote after loading high dose rate radionuclide brachytherapy; over 12 channels* (work RVU = 4.89, 20 minutes pre-service, 90 minutes intra-service, 20 minutes post-service) and MPC code 90966 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older* (work RVU = 4.26, 75 minutes intra-service). **The RUC recommends a work RVU of 4.29 for CPT code 77295.**

Practice Expense:

The PE Subcommittee discussed this code in great detail and requested that the specialty revise the spreadsheet and represent to the Subcommittee. The updated spreadsheet addressed the Subcommittee's concerns. The RUC accepted the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee.

New Technology:

CPT code 772X1X 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 recommendations for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Optical Endomicroscopy (Tab 15)

Jonathan Myles, MD, (CAP); Michael McEachin, MD, (CAP) and John Hart, MD, (CAP)

In the 2012 Medicare Physician Fee Schedule (MFS) Final Rule the Centers for Medicare and Medicaid Services (CMS) requested that the RUC review CPT codes 43235 and 45378. At the February 2012 CPT Editorial Panel meeting, the specialty societies presented two new endoscopic procedures for optical endomicroscopy: 43206 and 43252 as well as one new pathology procedure for optical endomicroscopy: 88375 *Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session*. In the final rule, CMS stated that if new codes are introduced within a family, the entire family should be reviewed in order to maintain relativity and avoid separate valuations of codes within a specific family. Because the existing family of codes were scheduled for review at either the October 2012 or January 2013 RUC meetings, the RUC agreed with the specialty societies that survey and review of the family of codes should be delayed in order to maintain relativity and meet CMS standards. CPT code 88375 was surveyed and presented at the January 2013 RUC meeting.

88375 Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session

Prior to reviewing the survey results, the RUC reviewed the survey methodology, as approved by the Research Subcommittee, used by the specialty society to ascertain responses to this low volume procedure. The survey results consisted of a random survey of College of American Pathologists (CAP) members combined with outreach to pathologists identified by a specific vendor. The RUC reviewed the survey results from practicing pathologists and recommend the following physician time components: pre-service time of 5 minutes and intra-service time of 25 minutes.

The RUC agreed with the specialty society that the survey 25th percentile work RVU of 1.08 is an accurate measure of the physician work involved in this service. To validate this value, the RUC compared the surveyed code to key reference service 88331 *Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen* (work RVU= 1.19) and agreed that although the pathologist will review more images (in real time) during an optical endomicroscopy session, the intensity and urgency of reviewing frozen sections during surgery accounts for the greater physician work in the reference code. The RUC also reviewed CPT codes 11311 *Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm* (work RVU= 1.10) and 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) and noted that both codes have identical intra-service time, 25 minutes, as the surveyed code and justifies the recommended work value for 88375. **The RUC recommends a work RVU of 1.08 for CPT code 88375.**

Practice Expense:

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

New Technology:

This service 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.

Percutaneous Closure Patent Ductus Arteriosus (Tab 16)

**Richard Wright, MD, (ACC); Cliff Kavinsky, MD (SCAI)
Facilitation Committee #2**

In October 2012, the CPT Editorial Panel established new code 9358X2 *Percutaneous transcatheter closure of patent ductus arteriosus* with moderate sedation inherent to report percutaneous transcatheter closure of patent ductus arteriosus and editorially revised the parenthetical note following three codes (93462, 93561 and 93562) for proper reporting of these services.

The RUC reviewed the survey results from 41 cardiologists for 9358X2 and determined that the survey 25th percentile work RVU of 14.00 and median intra-service time of 60 minutes appropriately accounts for the physician work and time required to perform this service. The RUC compared the surveyed service to code 92941 *Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel* (RUC recommended work RVU of 12.32 and 70 minutes intra-service time). The RUC reviewed the intra-service description for 9358X2 and determined that although the surveyed service requires 10 minutes less intra-service time it is more intense compared to the reference code. The specialty societies noted that the physicians who perform this service 20 or more times a year indicated a higher intra-service time of 75 minutes, which supports the comparison to 92941. The RUC agreed that the surveyed service is a rare procedure, therefore the physicians who are more familiar with performing it, more appropriately assessed the time required. Lastly, the RUC noted that 92941 is typically performed on an adult, whereas 9358X2 is performed on an infant and the work intensity difference between these two services is appropriate.

To gauge the work value differential between performing the same service on a child versus an adult the RUC compared 93530 *Right heart catheterization, for congenital cardiac anomalies* (work RVU=4.22) to 93451 *Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed* (work RVU = 2.72). The differential is 55% between these two services. The RUC reviewed 59076 *Fetal shunt placement, including ultrasound guidance* (work RVU = 8.99) and multiplied it by the observed child/adult work differential ($8.99 \times 1.55 = 13.95$), which results in a work RVU approximately the same as the survey 25th percentile work RVU. **The RUC recommends a work RVU of 14.00 for CPT code 9358X2.**

RUC Database Flag

The RUC recommends flagging this code in the RUC database as not to use to validate physician work because the median survey intra-time may not reflect the appropriate intra-service time compared to those who frequently perform this service.

Practice Expense

There are no direct practice expense inputs recommended for this service.

Percutaneous Alcohol Ablation of Septum (Tab 17)

Richard Wright, MD, (ACC); Cliff Kavinsky, MD (SCAI)

In October 2012, the CPT Editorial Panel created new code 9358X1 *Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed* to describe percutaneous transcatheter alcohol septal ablation, a procedure that reduces septal thickness to improve left ventricular outflow tract obstruction in patients with hypertrophic cardiomyopathy.

The specialty society indicated that this is a low volume service, with fewer than 60 physicians actively performing this service in the United States. However, the specialty societies gathered 29 responses with a median service performance rate of 5 in the last year. Given this, the RUC was confident that the survey respondents had adequate knowledge of the service and accurately valued the physician work required to perform this service at the survey 25th percentile (work RVU of 14.00).

The specialty societies indicated the pre-service work for this procedure necessitates a detailed analysis and review of all the echocardiographic measurements performed ahead of time, review the coronary angiogram, understanding exactly which tiny hair-like structures the physician will go to before starting the procedure and the physician must have a meticulous plan prior to entering the lab. The RUC determined that 58 minutes pre-time, 90 minutes intra-service time and 40 minutes immediate post-service time is appropriate to perform this service. The RUC compared the surveyed code to key reference service 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU = 17.97 and 120 minutes intra-service time) and determined that 93580 requires 30 minutes more intra-service time to perform but requires less mental effort, technical skill and psychological stress than 9358X1, in which you are inducing a heart attack. The RUC also compared 9358X1 to 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU =14.05 and 120 minutes intra-service time) to support the recommended value. **The RUC recommends a work RVU of 14.00 for CPT code 9358X1.**

New Technology

This service 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.

Practice Expense

This service is primarily performed in a facility and does not have direct practice expense inputs.

Total Body and Selective Head Hypothermia (Tab 18)

Steven E. Krug, MD, FAAP (AAP)

In October 2012, the CPT Editorial Panel created CPT codes 994XX1 and 994XX2 to replace CPT Category III codes, 0260T and 0261T, which describe services for hypothermia in a critically ill neonate per day. These services are no longer experimental and are part of the standard of care in neonatal intensive care units and as such are being valued in as CPT Category I codes.

CPT codes 994XX1 *Total body systemic hypothermia in a critically ill neonate per day (List separately in addition for code for primary procedure)* and 994XX2 *Selective head hypothermia in a critically ill neonate per day (List separately in addition for code for primary procedure)* were surveyed for the January 2013 RUC meeting. The RUC reviewed the survey results from 52 neonatologists and noted the low performance rate for this service with a median of 6 performed per year for 994XX1 and a median of 0 performed per year for 994XX2. The RUC was concerned that an add-on code that can be billed once per day rather than time based may overlap with other neonatal critical care services. The RUC was also concerned with how the survey respondent arrived at 60 minutes of intra-service time for this service in the midst of the other services they are providing to a critically ill neonate throughout the day. The specialty explained that the Sarnat score, which measures six basic components of neurological function, must be taken every 4 hours, requiring 5-10 minutes for each evaluation. This, plus the assessment of continuous amplitude EEG monitoring, will result in at least 60 minutes of intra-service time.

The RUC determined that because of the low performance rate the survey data could not be considered reliable. Furthermore, there was concern that these services overlapped with the critical care services. For these reasons, the RUC decided that these codes should be carrier priced. The RUC recommends that the specialty work with the Research Subcommittee to determine an appropriate method to survey these services for the October 2013 RUC meeting. **The RUC recommends carrier pricing for CPT code 994XX1 and 994XX2.**

Practice Expense:

This service is primarily performed in a facility and does not have direct practice expense inputs associated with it.

X. CMS Request – CMS High Expenditure Procedure Codes/Other Screen

Destruction of Premalignant Lesions (Tab 19)

Brett Coldiron, MD, (AAD); Michael Bigby, MD (AAD); Bruce Deitchman, MD, (AAD); Mark Kaufman, MD, (AAD) and Mollie MacCormack, MD, (AAD)

In the July 19, 2011 Proposed Rule, CPT code 17004 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions* was identified through the High Expenditure Procedural screen. In September 2011, the Relativity Assessment Workgroup (RAW) reviewed this family of services and recommended that the specialty societies submit action plans for January 2012. In January 2012, the RUC recommended that this service be surveyed for physician work and PE for the January 2013 RUC meeting.

In January 2013, the RUC reviewed the survey results for these services and agreed with the specialty society that there may have been confusion among the survey respondents. Specifically, for CPT code 17004, the surveyed time may not have accurately reflected the physician work to treat the typical number of lesions (15 or more). The RUC recommended that the specialty society consider adding a question to the survey instrument to determine the typical number of lesions for this code. The specialty society submitted a request to withdraw the issue and resurvey for the April 2013 RUC meeting which was approved.

Arthroplasty (Tab 20)

**William Creevy, MD, (AAOS); John Heiner, MD, (AAOS); David Halsey, MD, (AAHKS); Mark Froimson, MD, (AAHKS) and Frank Voss, MD, (AAHKS)
Facilitation Committee #2**

In the July 19, 2011 Proposed Rule for the 2012 Medicare Fee Schedule, CMS identified CPT code 27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft* and 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)* as high expenditure procedural codes. CMS also identified CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* as a Harvard-valued service with Annual Allowed Charges Greater than \$10 million.

Prior to valuing these procedures, the specialty societies presented compelling evidence to justify a change in the physician work value. Specifically, the physician work and time components of CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* were Harvard valued. Since that time the technique and technology to perform these services has changed. There have been considerable advances in technology and technique since this code was reviewed in the Harvard survey. Implant geometry, materials, fixation methods, and bearing surfaces have changed significantly. Mobile bearing components have been developed as an alternative to fixed bearing designs. More precise systems for accurate and limited bone cuts as well as limb alignment are utilized. Minimally invasive procedures with smaller incisions and limited soft tissue disruption have been developed. All of these factors have changed the physician work during a unicompartmental knee arthroplasty (UKA). Historical indications for UKA included unicompartmental arthritis, age greater than 60 years, patients with a low demand for activity, range of motion arc of 90 degrees with less than 5 degree flexion deformity, weight less than 180 pounds and an intact ACL. These patients are more active and demand better outcomes. These patients may also present with one of the following conditions: rheumatoid arthritis (RA), skeletal dysplasia, post-traumatic arthritis, infections, ligament injury reconstruction, ACL deficiency and patellofemoral arthritis. Primary osteonecrosis is now also considered and acceptable indication for UKA. Given this information, the RUC accepted compelling evidence that the current work RVU of 16.38 for 27446 is potentially misvalued.

There was also discussion regarding intra service time. It was noted that surveyed intra-service time decreased compared to current time. Specifically, for CPT code 27130, surveyed intra service time was 100 minutes compared to 135 minutes; for CPT code 27446 surveyed intra-service time was 90 minutes compared to 105 minutes; and lastly, for CPT code 27447, surveyed intra service time was 100 minutes compared to 124

minutes. However, the RUC confirmed that when these codes were reviewed at the September 2005 RUC meeting, physician time was based on data from the National Surgical Quality Improvement Program (NSQIP) rather than survey data. The RUC confirmed that the actual survey data from September 2005 was similar to the recommended survey time. For example, code 27130 had 135 minutes of NSQIP intra-service time as opposed to 110 minutes based on the survey. Therefore, the RUC agreed with the specialty societies that the recommended survey physician time data for this series of codes is appropriate and relative to past surveys.

27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

The RUC reviewed survey results from 157 orthopedic surgeons and determined that a work RVU 19.60, a direct crosswalk to 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace* (work RVU=19.60) is appropriate. These two services require the same intra service time and similar total time and complexity. The RUC also noted that the work of 27130 and 27447 require the same physician time and complexity to perform, and therefore should be valued the same. To further support this value, the RUC reviewed CPT codes 45400 *Laparoscopy, surgical; proctopexy (for prolapse)* (work RVU=19.44) and 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy* (work RVU=19.35) and agreed that these services require similar work and intensity. The RUC also reviewed key reference service 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU=22.13) and agreed that since the time and intensity is greater for 23472, this should be valued higher. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that three hospital visits, (2) 99231 and (1)99232, one discharge day (99238) and three office visits, (1) 99212 and (2) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later on the same day of surgery to evaluate wound, complete neuromuscular exam and assess the need for continued antibiotics. The RUC noted that although the number of hospital days has decreased from four to three, the overall post-operative work has not substantially changed and is now captured in post-operative office visits. The surgeon is typically involved in intensive care coordination with the primary care provider and relating to physical and occupational therapy. In addition, the physician will complete a musculoskeletal exam on the entire extremity as well as a neurovascular exam. Determining a gait pattern for these patients is essential since the extremity will be considered non-weight bearing post-surgery. **The RUC recommends a work RVU of 19.60 for CPT code 27130.**

27446 Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

The RUC reviewed survey results from 138 orthopedic surgeons and determined that a work RVU of 17.48, a direct crosswalk to CPT code 27709 *Osteotomy; tibia and fibula* (work RVU=17.48) is appropriate. Although, the intra service time of 27709 is greater, the RUC agreed that 27446 is a more complex procedure. To further support this value, the RUC reviewed CPT codes 46710 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach* (work RVU=17.14) and 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2* (work RVU=17.69) and agreed that the physician work and complexity of these services are similar. The RUC reviewed and discussed the appropriate number and level of post-operative visits and

determined that two hospital visits, (1) 99231 and (1) 99232, one discharge day (99238) and three office visits, (1) 99212 and (2) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later on the same day of surgery to evaluate wound, complete neuromuscular exam and assess the need for continued antibiotics. The RUC noted that although the number of hospital days has decreased from four to two, the overall post-operative work has not substantially changed and is now captured in post-operative office visits. The surgeon is typically involved in intensive care coordination with the primary care provider and relating to physical and occupational therapy. In addition, the physician will complete a musculoskeletal exam on the entire extremity as well as a neurovascular exam. Determining a gait pattern for these patients is essential since the extremity will be considered non-weight bearing post-surgery. **The RUC recommends a work RVU of 17.48 for CPT code 27446.**

27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

The RUC reviewed survey results from 157 orthopedic surgeons and determined that a work RVU 19.60, a direct crosswalk to 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace* (work RVU=19.60) is appropriate. These two services require the same intra service time and similar total time and complexity. The RUC also noted that the work of 27130 and 27447 require the same physician time and complexity to perform, and therefore should be valued the same. To further support this value, the RUC reviewed CPT codes 45400 *Laparoscopy, surgical; proctopexy (for prolapse)* (work RVU=19.44) and 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy* (work RVU=19.35) and agreed that these services require similar work and intensity. The RUC also reviewed key reference service 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU=22.13) and agreed that since the time and intensity is greater for 23472, this should be valued higher. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that three hospital visits, (2) 99231 and (1)99232, one discharge day (99238) and three office visits, (1) 99212 and (2) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later on the same day of surgery to evaluate wound, complete neuromuscular exam and assess the need for continued antibiotics. The RUC noted that although the number of hospital days has decreased from four to three, the post-operative work has not substantially changed and is now captured in post-operative office visits. The surgeon is typically involved in intensive care coordination with the primary care provider and relating to physical and occupational therapy. In addition, the physician will complete a musculoskeletal exam on the entire extremity as well as a neurovascular exam. Determining a gait pattern for these patients is essential since the extremity will be considered non-weight bearing post-surgery. **The RUC recommends a work RVU of 19.60 for CPT code 27447.**

Practice Expense:

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

Work Neutrality:

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

Thromboendarterectomy (Tab 21)

Gary Seabrook, MD, (SVS); Robert Zwolak, MD; (SVS) Mathew Sideman, MD, (SVS); Michael Sutherland, MD, (SVS)

Facilitation Committee #2

CPT code 35301 was identified by CMS in the 2012 Proposed Rule through the High Expenditure Procedural screen. In January 2012, the Relativity Assessment Workgroup (RAW) recommended this service be surveyed for presentation at the January 2013 RUC meeting.

35301 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision

Prior to valuing this procedure, the specialty societies presented compelling evidence to justify a change in the physician work value. First, the patient population has changed since the last RUC valuation in 1994. Clinical guidelines have since been better defined, which patients are suitable candidates for carotid endarterectomy vs. medical therapy or carotid artery stenting. This has led to a 44% decrease in Medicare utilization over the past decade. The smaller overall cohort size and the introduction of carotid stenting resulted in a different clinical population that received carotid endarterectomy in 2012 compared to 1994 when the code was last reviewed. In addition to the changing cohort of patients undergoing carotid endarterectomy as described above, this population is older. When comparing the patient characteristics from 2011 to those of 1994 when the code was last reviewed, there has been an 11% increase in the percentage of patients who are over 75 years old and a 69% increase in the percentage of patients who are over 85 years old.

Second, since the last review in 1994, the dominant provider has changed, indicating that the patient population has indeed changed.

Specialty	1994	2011
General Surgery	35%	22%
Vascular Surgery	23%	47%
Thoracic Surgery	22%	12%
Cardiac Surgery	7%	14%
Neurosurgery	6%	2%

Given these arguments, the RUC accepted compelling evidence that the current work RVU of 19.61 for CPT code 35301 is potentially misvalued.

The RUC reviewed the survey results from 117 vascular surgeons and recommends the following physician time components: pre-service time= 75 minutes, intra-service time= 120 minutes and immediate post-service time= 30 minutes. The RUC agreed with the specialty society that 12 minutes of positioning time above the standard pre-service package is warranted to account for the application of neuro-monitoring equipment and to properly position the patient with the neck extended and rotated away from the operative side. This allotment of minutes has precedence in CPT code 60240 *Thyroidectomy, total or complete*, approved by the RUC and CMS in the Fourth Five-Year Review.

The RUC noted that while they were convinced the current work value is misvalued, the survey intra-service time of 120 minutes is 24 minutes less than the current time. The specialty society explained that while there is only one carotid endarterectomy code there are three distinct methods to perform this operation, and each of them has a different intra-time and intra-intensity profile. The fastest way to perform a carotid endarterectomy is with the patient wide awake under the sterile drapes. Surgeons who use this awake carotid endarterectomy method must operate very quickly because of potential difficulty with patients becoming uncomfortable and altering positions. While this procedure is the fastest carotid endarterectomy method, it is also the most intense, since the physician is performing an incredibly precise operation with the patient awake. Thus, surgeons who use this approach are likely to report short intra-service times. The slowest way to do a carotid endarterectomy is with the patient under general anesthesia with insertion of a blood-flow shunt around the operative site. This procedure takes longer because the shunt must be inserted and removed. Thus, when the surgeon shunts the patient, the carotid endarterectomy takes more intra-time. It is still a very intense procedure, but a slightly less so than the awake approach. The third way to do this operation is with the patient under general anesthesia with selective shunting using neuro-monitoring, EEG SSEP - so that shunt placement is done only on those patients whose brain becomes ischemic when the carotid artery is clamped. Only about 10% of patients actually need a shunt. This neuro-monitoring selective-shunting approach is faster than the shunt everyone approach, but slower than the awake patient approach. Therefore, the RUC agreed that the shorter intra-service time reflects a shift in the blend of the three methods to do carotid endarterectomy away from the general-anesthesia shunt method – which many surgeons still use and is the longest – to the neuro-monitored selective-shunt approach and the fully awake carotid endarterectomy patient, which are generally shorter, more intense methods.

The RUC then reviewed the survey's estimated work values and agreed that the respondents overestimated the physician work involved in this service, with a 25th percentile work RVU of 23.00. To determine an appropriate value for this procedure, the RUC compared the surveyed code to CPT code 35231 *Repair blood vessel with vein graft; neck* (work RVU= 21.16) and noted that both services are vascular procedures with identical intra-service time, 120 minutes, and similar total time. Therefore, RUC recommends directly crosswalking the work value (21.16) for this reference code 35231 to the surveyed code 35301. To justify a work RVU of 21.16, the RUC compared the surveyed code to 35621 *Bypass graft, with other than vein; axillary-femoral* (work RVU= 21.03) and agreed that since these vascular procedures have identical intra-service time and comparable total times, the two services should be valued similarly. Finally, the RUC reviewed CPT code 49203 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or*

secondary tumors; largest tumor 5 cm diameter or less (work RVU= 20.13) and also agreed that this code should be valued similarly to 35301 because both services have identical intra-service time and comparable physician work. **The RUC recommends a work RVU of 21.16 for CPT code 35301.**

Practice Expense:

The RUC reviewed and approved the modifications to the direct practice expense as recommended by the Practice Expense Subcommittee.

Selective Catheter Placement (Tab 22)

Gary Seabrook, MD, (SVS); Michael Sutherland, MD, (SVS); Mathew Sideman, MD, (SVS); Sean Tutton, MD, (SIR); Michael Hall, MD, (SIR); Robert Vogelzang, MD, (SIR); Jerry Niedzwiecki, MD, (SIR); Zeke Silva, MD, (ACR); Richard Wright, MD, (ACC) and Clifford Kavinsky, MD, (SCAI)

CPT code 36245 was identified as a Harvard valued code with allowed charge greater than \$10 million and Codes reported together greater than 75% of the time. At the January 2012 RUC Meeting, the Relativity Assessment Workgroup (RAW) recommended a survey of physician work and practice expense for the January 2013 RUC Meeting.

36245 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family

The specialty societies indicated and the RUC agreed that there was compelling evidence that this service is now performed primarily by a different specialty and the work has changed. This service is currently a Harvard-valued code and was initially performed by radiology but is now performed primarily by cardiology and vascular surgery. Additionally, the new endovascular revascularization code set bundling for CPT 2011 includes the selective catheter placement that was previously reported with this service. Therefore, the population that will now receive this service has changed. The remaining reporting of this code will include catheterization of the mesenteric vessels and lumbar vessels, which are inherently more complex than the catheter selections associated with lower extremity revascularization diagnostic and intervention procedures such that 36245 represents increased work. The RUC agreed that the caliber of the vessels and selective branches are much more susceptible to the complication of thrombo-embolic injury. Lastly, moderate sedation is now inherent in this procedure.

The RUC reviewed the survey results from 193 physicians who perform CPT code 36245 and determined that the survey 25th percentile work RVU of 4.90 appropriately accounts for the work required to perform this service. The RUC noted that 36245 may be reported with a number of different S&I codes including 75726 *Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation* (work RVU = 1.14) for diagnostic studies. Because these code combinations were valued as individual component codes, no potential for duplication of physician work exists. The specialty indicated and the RUC agreed that the immediate-post service time is the same as the key reference service and therefore reduced the immediate post-time to 20 minutes. The RUC compared the surveyed code to the key reference 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) and determined the physician time was the same. The RUC agreed that 36246 requires slightly more physician work because the work of 36245 is inherent in 36246 as the second order catheter placement is the result of advancing a first order

catheter selection an additional selective step further in the vascular bed. Additionally, the initial second order artery branches are more complex than the first order artery branch because the second order branches are smaller, more susceptible to injury and their selection is, as such, more intense and complex to perform. For further support, the RUC compared 36245 to similar service 52276 *Cystourethroscopy with direct vision internal urethrotomy* (work RVU = 4.99 and 35 minutes intra-service time) and determined the survey 25th percentile supported the relativity among other similar services. **The RUC recommends a work RVU of 4.90 for CPT code 36245.**

Practice Expense:

The Practice Expense Subcommittee made slight modifications to the direct practice expense inputs: line 31 prepare room reduced from 3 to standard 2 minutes; line 38 and 39 zeroed out because right above it are the assistants performing the procedure, including the angiography technician; Equipment – angiography room, contrast media warmer and exam light all reduced to 54 minutes; addition of stretcher for monitoring the patient for conscious sedation for 4 hours following the procedure (EF018) for 240 minutes. In addition the RUC discussed that the standard monitoring time for arterial procedures is a minimum of 4 hours. Although other services only require 2 hours of monitoring, this service is rarely performed in the physician’s office and in the small number of cases when it is, the patients are very complex. For this small subset, it is critical for patient safety that a minimum of 4 hours monitoring is administered. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Percutaneous Thrombectomy (Tab 23)

Sean Tutton, MD, (SIR); Jerry Niedzwiecki, MD, (SIR); Michael Hall, MD, (SIR); Robert Vogelzang, MD, (SIR); Zeke Silva, MD, (ACR); Gary Seabrook, MD, (SVS); Michael Sutherland, MD, (SVS); Chet Amedia, MD, (RPA); (Rob Kossmann, MD; (RPA) and Tim Pfleiderer, MD, (RPA)

CPT code 36870 was first identified in September 2007 through the Site-of-Service screen. Subsequently, this code was also identified by CMS in the Medicare Proposed Rule for 2012 under the High Expenditure Procedural Screen. Prior to surveying this code for the January 2013 RUC meeting, the specialty societies requested that CMS change the global period from a 090 to 000 to reflect current endovascular procedure. CMS accepted this request and the service was surveyed as a 000-day global.

36870 Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

Prior to valuing this service, the specialty societies presented compelling evidence to justify a change in the physician work value of CPT code 36870. First, the patient population has changed since the previous RUC valuation in April 2000. The success of the “Fistula First program,” a public-private partnership dedicated to improving care for kidney disease patients by increasing AV fistula placement and use in suitable hemodialysis patients, has led to increased numbers of patients dialyzing with an arteriovenous fistula or graft (86.7% in 2003 and 92.7% in 2012). To obtain this greater prevalence of useful fistulae and grafts, more complex surgical techniques such as transpositions and accesses in unusual anatomic locations have been utilized. Additionally, the implementation of effective surveillance programs in dialysis facilities combined with pre-emptive angioplasty have reduced overall thrombosis rates. The

combined effect of these changes over time has been that the procedure has become significantly more challenging. The grafts and fistulae that thrombose tend to be complex and to have undergone numerous prior procedures. This leads to the thrombectomy procedure being more complex and intensive of physician time, skill and resources.

Second, resultant from the above described changes, the specialty mix that provide this service has changed significantly in the last thirteen years. Since only diagnostic and interventional radiologists took part in the April 2000 survey of this procedure, the current work RVU is not based upon the recommendations of the current majority of physicians now practicing this service.

Specialty	2002	2007	2011
Diagnostic Radiology	70%	54%	38%
Nephrology	4%	16%	26%
Vascular Surgery	2%	6%	13%
Interventional Radiology	14%	13%	10%
General Surgery	2%	6%	6%

Given these arguments, the RUC accepted compelling evidence that the current work RVU of 5.20 for CPT code 36870 is potentially misvalued.

The RUC reviewed the 2010 Medicare Claims 5% Billed Together sample file and noted there are three services commonly billed on the same date of service with 36870: 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)* (95% reported together), 35476 *Transluminal balloon angioplasty, percutaneous; venous* (79% billed together) and 36148 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention* (62% billed together). The specialties noted that in order to perform AV shunt thrombectomy the access code, 36147, has to be billed on the same date. **With this understanding, the RUC referred CPT code 36870 to the CPT Editorial Panel to bundle the appropriate services into 36870.**

Global Period:

The RUC noted that when the CPT Editorial Panel creates a new code(s) to bundle these services it will be surveyed as a 000-day global procedure, per the request of the specialty society and approval by CMS.

Laminectomy (Tab 24)

Alexander Mason, MD, (CNS); Willam Creevy, MD, (AAOS) and William Sullivan, MD, (NASS)

In the July 19, 2011 Proposed Rule, CPT code 63047 was identified by CMS through the High Expenditure Procedure Code screen. At the January 2012 RUC Meeting, the Relativity Assessment Workgroup (RAW) recommended a survey of physician work and practice expense for the January 2013 RUC Meeting.

The specialty societies indicated that they considered that the work of these procedures has increased due to the changing patient characteristics. With the growing frequency of non-surgical spine intervention, patients are increasingly presenting for surgery having had prior procedures and studies are beginning to show an increase in the work and length of stay for these patients. Many Medicare and private payers are beginning to require longer waiting periods before spine surgery and during this time patients often receive other intervention, making the patients who do receive surgery more difficult. The specialty societies decided to recommend the current value rather than the survey 25th percentile, although monitoring the trend in patient characteristics is warranted as the work involved in this procedure has already changed since 2005 and is likely to continue to evolve as the patients become more complex and the physician work greater. The RUC was sympathetic to the potential of compelling evidence and notes this for any future review.

63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

The RUC reviewed the survey results from 96 physicians who perform this service and determined that the current work RVU of 15.37 and 75 minutes of pre-time, 90 minutes of intra-service time and 30 minutes of immediate post-service time appropriately accounts for the physician work and time required to perform this service. The current value is below the survey 25th percentile work RVU of 16.00. It was also noted by several reviewers that there was considerable evidence the recommended work RVU may have been too low and that an increase may have been warranted. The specialty societies agreed with the commenters but noted the current literature did not quite support a request for compelling evidence; however the societies expect there may be compelling evidence in the near future of a change in work and therefore may nominate the codes for re-review at that time. The RUC compared the surveyed code to key reference service 63042 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar* (work RVU = 18.76 and 120 minutes intra-service time) and determined that 63042 requires 30 minutes more intra-service time, and therefore, the survey code is appropriately valued lower. For further support, the RUC compared the surveyed service to similar service 63620 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion* (work RVU = 15.60 and 90 minutes intra-service time) and MPC code 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)*; (work RVU = 17.31 and 120 minutes intra-service time) and determined that maintaining the current work RVU supported relativity among similar services. **The RUC recommends a work RVU of 15.37 for CPT code 63047.**

63048 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 96 physicians who perform this service and determined that the current work RVU of 3.47 with 45 minutes of intra-service time appropriately accounts for the work required to perform this service. The current value is below the survey 25th percentile work RVU of 5.00. It was also noted by several reviewers that there was considerable evidence the recommended work RVU may have been too low and that an increase may have been warranted. The specialty societies

agreed with the commenters but noted the current literature did not quite support a request for compelling evidence; however the societies expect there may be compelling evidence in the near future of a change in work and therefore may nominate the codes for re-review at that time. The RUC compared the surveyed code to key reference service 22328 *Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment* (work RVU = 4.60 and 45 minutes intra-service time) and determined that the surveyed service is slightly less intense and complex to perform. For further support, the RUC compared the surveyed service to similar MPC services 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach* (work RVU = 4.88 and 45 minutes intra-service time) and 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes* (work RVU = 2.25) and determined that maintaining the current work RVU supported relativity among similar services. **The RUC recommends a work RVU of 3.47 for CPT code 63048.**

Practice Expense:

The RUC recommends the standard 090-day global direct practice expense inputs as approved by the Practice Expense Subcommittee for CPT code 63047.

Aqueous Shunt (Tab 25)

Stephen A. Kamenetzky, MD, (AAO) and Mark Sherwood, MD, (AAO)

CMS identified CPT code 66185 through the Harvard-Valued Annual Allowed Charges Greater than \$10 million screen. In October 2012, the RUC recommended that the specialty society survey codes 66180 and 66185 for January 2013.

In January 2013, the RUC reviewed the survey results for these services and it appeared that the post-operative visits were not calculated correctly. The RUC recommended postponing review of these services until April 2013, allowing the specialty society sufficient time to calculate the survey responses for post-operative visits.

MRI-Brain (Tab 26)

Zeke Silva, MD, (ACR); Greg Nicola, MD, (ASN)

Facilitation Committee #3

In the Proposed Rule for 2012, CMS identified CPT code 70551 through the High Expenditure Procedural Code screen. In January 2012, the RUC recommended that the specialty societies survey the physician work and present to the RUC in the CPT and Medicare Physician Fee Schedule 2014 cycle. At this time, CPT code 70552 and 70553 were added to the survey list as they are part of the MRI of the brain family of services.

70551 Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material

The RUC reviewed the survey results from 69 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 18 minutes and post-service time of 5 minutes. The RUC agreed that 5 minutes of pre-service time is necessary to review clinical history, prior studies and communicate with the technologist. The RUC also noted that the physician time is currently incorrectly reported in the physician time file in the RUC database. CPT code

70551 has not been previously reviewed by the RUC and thus the current physician time for this service is 28 total minutes with a time source of CMS/Other.

The RUC reviewed the survey's estimated work RVUs and agreed with the specialty societies that the respondents overestimated the physician work involved in this service, with a 25th percentile work RVU of 1.60. Therefore, since there is no compelling evidence to change the value of this procedure, the current value of 1.48 is appropriate for this service. To validate this work value, the RUC compared the surveyed code to CPT code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.40) and noted that while both services have identical physician time components, 70551 should be valued slightly higher because it is a more intense procedure, performed predominantly in the inpatient hospital setting. The RUC also reviewed CPT code 70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 1.75) and agreed that since the reference code has 10 additional minutes of total time compared to the surveyed code, 70551 is correctly valued below 70496. **The RUC recommends a work RVU of 1.48 for CPT code 70551.**

70552 Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)

The RUC reviewed the survey results from 69 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 7 minutes. The RUC agreed that 5 minutes of pre-service time is necessary to review clinical history, prior studies and communicate with the technologist.

The RUC reviewed the survey's estimated work RVUs and agreed with the specialty societies that the respondents overestimated the physician work involved in this service, with a 25th percentile work RVU of 1.81. Therefore, since there is no compelling evidence to change the value of this procedure, the current value of 1.78 is appropriate for this service. To validate this work value, the RUC compared the surveyed code to CPT code 73222 *Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)* (work RVU= 1.62, 5 minutes pre-time, 20 minutes intra-time and 8 minutes post-time) and agreed that while both codes have identical intra-service time, MRI of the brain is a more intense procedure and should be valued higher. The RUC also reviewed the key reference service code 70543 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU= 2.15, 8 minutes pre-time, 15 minutes intra-time and 10 minutes post-time) and noted that while the reference code has less intra-service time, the survey respondents indicated that 70543 is a more intense service than 70552 and should be valued higher. **The RUC recommends a work RVU of 1.78 for CPT code 70552.**

70553 Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences

The RUC reviewed the survey results from 69 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 25 minutes and post-service time of 7 minutes. The RUC agreed that 5 minutes of pre-service time is necessary to review clinical history, prior studies,

communicate with the technologist and perform tasks relating to the administration of contrast materials.

The RUC reviewed the survey results and agreed with the specialty society that since there is no compelling evidence to change the value of this procedure, the current value of 2.36 is appropriate for this service. To validate this work value, the RUC compared the surveyed code to key reference service code 70543 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU= 2.15, 8 minutes pre-time, 15 minutes intra-time and 10 minutes post-time) and agreed that with higher intra-service time and intensity, 70553 should be valued higher than this reference code. Additionally, CPT code 71552 *Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences* (work RVU= 2.26, 7.5 minutes pre-time, 24 minutes intra-time and 10 minutes post-time) was reviewed and the RUC agreed that 70553 is a more intense procedure and should be valued slightly higher. **The RUC recommends a work RVU of 2.36 for CPT code 70553.**

Finally, to ensure that the recommended work values reflect incremental work that is relative to other similar codes in the RBRVS, the RUC compared these codes to several other families of codes. After review, the RUC was assured that the recommended work values are appropriate and relative to similar services.

Radiation Treatment Delivery-PE Only (Tab 27)

Najeeb Mohideen, MD, (ASTRO); Micheal Kuettel, MD, PhD, (ASTRO); Dwight Heron, MD, (ASTRO); and Gerald White, MS (ASTRO)

In the July 30, 2012 Proposed Rule for the 2013 Medicare Fee Schedule, CMS requested that the RUC review the practice expense (PE) for CPT Codes 77418 and 77373. CMS identified these codes as having stand alone PE procedure time, defined as (PE) RVUs developed utilizing procedure time assumptions that are not based on physician work. The RUC recommended that these services be reviewed for practice expense in October 2012. In October 2012, the RUC's Practice Expense Subcommittee met and discussed the CMS request. The PE Subcommittee discussed the procedure time related to 77373 and the procedure time and number of staff related to 77418. After review of the practice expense inputs the RUC's Practice Expense Subcommittee and the RUC agreed that since there is no physician work associated with this code, in order to ensure accurate procedure times for 77373 and 77418, the specialty society should conduct a survey for clinical staff time. The specialty societies agreed to conduct a survey for 77373, but decided to refer CPT code 77418 to the CPT Editorial Panel.

77373 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

The specialty societies used a modified PE survey tool, reviewed and approved by the Research Subcommittee to conduct a random survey of their office based membership. The PE Subcommittee reviewed the survey results from 18 radiation oncologists, radiologists and physicists and agreed with the specialties that the overall clinical time is consistent with the recently modified/implemented 2013 CMS direct inputs. The PE Subcommittee agreed with the adjustments made by the specialties to some of the specific steps in order to more accurately reflect survey results. In addition, as requested by the RUC, the specialties have provided schedules to demonstrate the typical time

reserved for this service. Schedules have been included as attachments with this rationale. **The RUC recommends the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee.**

77418 Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session

The specialty societies discussed CPT code 77418 with the Research Subcommittee while preparing for the January 2013 RUC meeting survey cycle. During the conference call to review the modified PE survey tool it became clear that taking the issue to CPT was the most effective way to deal with the concerns surrounding the code. CPT code 77418 can encompass procedures with a range of time and complexity and would be more adequately segmented by two codes, one for simple and one for complex. **The RUC recommends that CPT code 77418 be referred to CPT.**

Intravenous Infusion Therapy (Tab 28)

David H. Regan, MD, (ASCO); Samuel M. Silver, MD, (ASH); Alfonso E. Bello, MD, (ACR); Steve Schmitt, MD, (IDSA)

In the July 19, 2011 Proposed Rule for the 2012 Medicare Fee Schedule, CMS requested that the RUC review high expenditure procedural codes. CPT code 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* and CPT code 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour* were identified for review through this screen. In January 2012, the RUC recommended that the infusion codes be surveyed for physician work and practice expense for the January 2013 RUC meeting.

96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour

The RUC reviewed survey results from 68 hematology, oncology, rheumatology, and infectious diseases physicians and determined that the current work RVU of 0.21 appropriately accounts for the physician work required to perform this service. The RUC agreed with the specialties' recommendation to maintain the current times of 2 minutes pre-service, 5 minutes intra-service and 2 minutes post-service. The RUC compared the surveyed service to key reference service CPT code 96409 *Chemotherapy administration; intravenous, push technique, single or initial substance/drug* (work RVU= 0.24, 4 minutes pre-service, 5 minutes intra-service and 2 minutes post-service) and agreed with the survey respondents that 96365 requires less physician time to perform and is less intense and complex than 96409, accounting for the lower work value. The RUC also compared the surveyed service to MPC CPT code 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic* (work RVU= 0.21, 4 minutes pre-service, 3 minutes intra-service, 2 minutes post-service) and agreed with the survey respondents that 96365 requires the same total time to perform and is similar intensity to perform. **The RUC recommends a work RVU of 0.21 for CPT code 96365.**

96366 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour

The RUC reviewed survey results from 68 hematology, oncology, rheumatology, and infectious diseases physicians and determined that the current work RVU of 0.18 appropriately accounts for the physician work required to perform this service. The RUC

agreed with the specialties' recommendation of 5 minutes intra-service time. The RUC compared the surveyed service to key reference service CPT code 96361 *Intravenous infusion, hydration; each additional hour* (work RVU= 0.09, 3 minutes intra-service) and agreed with the survey respondents that 96366 requires more physician time to perform and is more intense and complex than 96361, accounting for the higher work value. The RUC also compared the surveyed service to similar service CPT code 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug* (work RVU= 0.20, 3 minutes pre-service, 4 minutes intra-service) and agreed with the survey respondents that 96366 requires less total time to perform and is slightly less intense to perform, accounting for the lower work value. **The RUC recommends a work RVU of 0.18 for CPT code 96366.**

96367 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour

The RUC reviewed survey results from 61 hematology, oncology, rheumatology, and infectious diseases physicians and determined that the current work RVU of 0.19 appropriately accounts for the physician work required to perform this service. The RUC agreed with the specialties recommendation of 1 minute pre-service and 5 minutes intra-service. The RUC agreed that although pre-service time for a ZZZ codes is not typical, when this service is reported the patient would be receiving a second hour of administration with a second drug, requiring pre-service time to prepare. The RUC agreed that complications may occur with administering a second drug and there is a greater likelihood of additional nurse/physician interaction as compared to 96366 (recommended work RVUs of 0.18), accounting for the slightly higher work value. The RUC compared the surveyed service to key reference service CPT code 96375 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug* (work RVU= 0.10, 1 minute pre-service, 3 minutes intra-service) and agreed with the survey respondents that 96367 requires more physician time to perform and is more intense and complex than 96375, accounting for the higher work value. The RUC also compared the surveyed service to similar service CPT code 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug* (work RVU =0.20, 3 minutes pre-service, 4 minutes intra-service) and agreed with the survey respondents that 96367 requires less total time to perform, accounting for the lower work value. **The RUC recommends a work RVU of 0.19 for CPT code 96367.**

96368 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion

The RUC reviewed survey results from 59 hematology, oncology, rheumatology, and infectious diseases physicians and determined that the current work RVU of 0.17 appropriately accounts for the physician work required to perform this service. The RUC agreed with the specialties' recommendation of 1 minute pre-service and 5 minutes intra-service. The RUC agreed that although pre-service time for a ZZZ codes is not typical, when this service is reported the patient would be receiving two drugs at the same time, requiring pre-service time to prepare. The RUC compared the surveyed service to key reference service CPT code 96375 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug* (work RVU= 0.10, 1 minute pre-service, 3 minutes intra-service) and agreed with the survey respondents that 96368 requires more physician time to perform and is more intense and complex than 96375, accounting for the higher work value. The RUC also compared the surveyed service to similar service CPT code 96411 *Chemotherapy*

administration; intravenous, push technique, each additional substance/drug (work RVU=0.20, 3 minutes pre-service, 4 minutes intra-service) and agreed with the survey respondents that 96368 requires less total time to perform, accounting for the lower work value. **The RUC recommends a work RVU of 0.17 for CPT code 96368.**

Practice Expense: The Practice Expense Subcommittee made modifications to the direct practice expense inputs for CPT code 96365: line 12 complete pre-service diagnostic and referral forms reduced from 3 to 2 minutes; line 13 coordinate pre-surgery services reduced from 3 to 0 minutes; line 17 review charts - obtain medical history reduced from 3 to the standard 0; line 18 greet patient and escort to infusion suite increased from 2 to the standard 3; line 19 obtain vital signs reduced from 5 minutes the standard for level 2 (4-6 vitals), to 3 minutes the standard for level 1 (1-3 vitals); line 35 start IV or access port/PICC reduced from 2 to 1. For CPT code 96366 the changes included: line 19 obtain vital signs reduced from 5 minutes the standard for level 2 (4-6 vitals), to 2 minutes for 2 vital signs taken. For CPT codes 96365, 96366 and 96367 the following supplies were removed: juice, apple, 1 oz (SK042), cup, drinking (SK018) and Graham crackers, 1 packet (SK040). The RUC recommends the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

Chemotherapy Administration (Tab 29)

David H. Regan, MD, (ASCO); Samuel M. Silver, MD, (ASH); Alfonso E. Bello, MD, (ACRrh)

In the July 19, 2011 Proposed Rule for the 2012 Medicare Fee Schedule, CMS requested that the RUC review high expenditure procedural codes. In January 2012, the RUC recommended that these services be surveyed for physician work and PE for the January 2013 RUC meeting.

96413 Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug

The RUC reviewed survey results from 79 hematology, rheumatology and oncology physicians and determined that the current work RVU of 0.28 appropriately accounts for the physician work required to perform this service. The RUC agreed with the specialties' recommendation to maintain the current times of 4 minutes pre-service, 7 minutes intra-service and 2 minutes post-service. The RUC compared the surveyed service to key reference service CPT code 96409 *Chemotherapy administration; intravenous, push technique, single or initial substance/drug* (work RVU=0.24, 4 minutes pre-service, 5 minutes intra-service, 2 minutes post-service) and agreed with the survey respondents that 96409 requires less physician time to perform and is less intense and complex than 96409, accounting for the lower work value. For additional support the RUC also compared the surveyed service to MPC CPT code 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic* (work RVU=0.21, 4 minutes pre-service, 3 minutes intra-service, 2 minutes post-service) and noted that 96413 has a higher intensity and complexity than code 96401 and has a greater amount of physician time, accounting for the higher work value. **The RUC recommends a work RVU of 0.28 for CPT code 96413.**

96415 Chemotherapy administration, intravenous infusion technique; each additional hour

The RUC reviewed survey results from 79 hematology, rheumatology and oncology physicians and determined that the current work RVU of 0.19 appropriately accounts for

the physician work required to perform this add-on service. The RUC agreed with the specialties' recommendation to maintain the current time of 5 minutes intra-service, which is consistent with the survey 25th percentile. The RUC compared the surveyed service to key reference service CPT code 96409 *Chemotherapy administration; intravenous, push technique, single or initial substance/drug*, (RVW 0.24, 4 minutes pre-service, 5 minutes intra-service, 2 minutes post-service) and noted that the codes have identical intra-service time, however 96415 has less total time, accounting for the lower work value. For additional support the RUC also compared 96415 to MPC code 96402 *Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic* (work RVU=0.19, 4 minutes pre-service, 3 minutes intra-service, 2 minutes post-service) and noted that although 96402 has more total time, it is less intense to perform accounting for the identical work value. Additionally, the increment work value increase of 0.02 between the comparison codes 96402 and 96401 to 96415 and 96417 respectively, reflects the identical work values. **The RUC recommends a work RVU of 0.19 for CPT code 96415.**

96417 *Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour*

The RUC reviewed survey results from 66 hematology, rheumatology and oncology physicians and determined that the current work RVU of 0.21 appropriately accounts for the physician work required to perform this add-on service. As this is an add-on code, the specialty societies did not survey for pre and post time, however, this was an oversight as this service does have pre-service work. The service involves an infusion of an additional drug for which the physician needs to confirm the order and calculate the dosage. This adds some pre-service time over and above that assigned to the initial infusion, CPT code 96413. The RUC agreed with the specialties' recommendation to maintain the current times of 2 minutes pre-service and 6 minutes intra-service. The RUC noted that CPT code 96417 is billed more than 50% of the time with an Evaluation and Management service, however the physician times associated with these codes are direct supervision and interactions with clinical staff, rather than face-to-face with the patient, so the Evaluation and Management physician time does not overlap with the service physician time. The RUC compared the surveyed service to key reference service CPT code 96409 *Chemotherapy administration; intravenous, push technique, single or initial substance/drug* (RVW 0.24, 4 minutes pre-service, 5 minutes intra-service, 2 minutes post-service) and noted that the codes have identical intra-service time, however 96417 has less total time, accounting for the lower work value. For additional support the RUC also compared 96417 to 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*, (work RVU=0.21, 4 minutes pre-service, 3 minutes intra-service, 2 minutes post-service) and noted that although 96401 has more total time, it is less intense to perform accounting for the identical work value. Additionally, the increment work value increase of 0.02 between the comparison codes 96402 and 96401 to 96415 and 96417 respectively, reflects the identical work values. **The RUC recommends a work RVU of 0.21 for CPT code 96417.**

Practice Expense: The Practice Expense Subcommittee made modifications to the direct practice expense inputs for CPT code 96413: line 12 complete pre-service diagnostic and referral forms reduced from 3 to 2 minutes; line 13 coordinate pre-surgery services reduced from 3 to 0 minutes; line 29 calculate BSA reduced from 1 to 0 minutes; line 36 maintain MSDS reduced from 1 to 0 minutes. For CPT code 96417 line 36 maintain MSDS was reduced from 1 to 0 minutes. For CPT codes 96413, 96415 and 96417 the following supplies were removed: juice, apple, 1 oz (SK042), cup, drinking (SK018) and

graham crackers, 1 packet (SK040). Also for CPT code 96413, the specialty recommended 8 minutes for nurse education and the RUC determined that 5 minutes was more appropriate for the time necessary for this activity. The RUC recommends the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

XI. Practice Expense Subcommittee (Tab 30)

Scott Manaker, MD, provided the Practice Expense Subcommittee report:

Doctor Manaker informed the RUC that the Practice Expense Subcommittee report outlines the progress that the Migration from Film to Digital Imaging Workgroup and the Contrast Imaging Workgroup has made to date. He explained that the Contrast Imaging Workgroup is working to improve standards and increase efficiency for the PE Subcommittee. Doctor Manaker directed the RUC to a table in the report that indicates major, minor or unchanged PE inputs resulting from the PE Subcommittee meeting. These changes were also detailed to the RUC as codes were reviewed throughout the meeting.

The RUC approved the Practice Expense Subcommittee report.

XII. Administrative Subcommittee (Tab 31)

J. Allan Tucker, MD provided the Administrative Subcommittee report:

Doctor Tucker indicated that the Subcommittee modified the Primary Care Rotating Seat Eligibility criteria, adding “or Medicaid” in order to include pediatricians.

Structure and Functions, Rotating Seat Policies and Election Rules:

Candidate Eligibility

The RUC approved that subspecialties deemed eligible for the Internal Medicine or other rotating seats may choose individuals that represent the interest of the subspecialty group and that a board certification in that particular specialty is not a requirement.

The Primary Care rotating seat candidate must be in active clinical practice, with at least 50% of his or her professional time in direct patient care. **The Primary Care rotating seat candidate must present documentation that he/she is defined as a primary care physician by Medicare or Medicaid (i.e., primary care bonus eligibility).** The Primary Care rotating seat candidate must be a physician with significant experience and expertise in broad-based chronic disease management, comprehensive treatment plan development and management, and preventive care.

The RUC approved the Administrative Subcommittee Report.

XIII. HCPAC Review Board (Tab 32)

Anthony Hamm, DC, provided the Health Care Professionals Advisory Committee Review Board report:

Dr. Hamm indicated that the RUC reviewed and provided recommendations for four new codes to more accurately describe and differentiate speech evaluation services. Dr. Hamm also informed the RUC that the HCPAC received a preliminary report that the Physical Medicine and Rehabilitation CPT Workgroup will begin at next week's CPT meeting.

Speech Evaluation (925XX1-925XX4)

CPT Code 92506 *Evaluation of speech, language, voice, communication, and/or auditory processing* was requested to be reviewed via Speech-Language Pathology Request/CMS Request. In February 2010, after reviewing the survey data for this service, ASHA agreed that more than one service is being represented under this code and requested the service be referred to the CPT Editorial Panel for further clarification. The HCPAC recommended that 92506 be referred to the CPT Editorial Panel to clearly describe the services being performed. In October 2012, the CPT Editorial Panel deleted 92506 and created four new codes to more accurately describe and differentiate speech-language pathology evaluation services.

925XX1 Evaluation of speech fluency (eg, stuttering, cluttering)

The HCPAC reviewed the survey results of 91 speech-language pathologists and determined that the survey median work RVU of 1.75 and 5 minutes pre-time, 90 minutes intra-time and 15 minutes immediate post-service time appropriately account for the work and time required to perform this service. The HCPAC compared the surveyed code to key reference service 96105 *Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour* (work RVU = 1.75 and 4 minutes pre-time, 60 minutes intra-time and 5 minutes post-time) and determined that 925XX1 requires 30 minutes more intra-service to assess the impact of stuttering, measure the frequency, duration and type of stuttering, administer fluency test measures, obtain and analyze a speech sample and identify other deficits all in a slow and calm pace to allow a proper response time for the patient. Additionally, the HCPAC agreed that immediate post-service time is appropriate to communicate the information to the parent as the typical patient is a child. **The HCPAC recommends a work RVU of 1.75 for CPT code 925XX1.**

925XX2 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)

The HCPAC reviewed the survey results of 165 speech-language pathologists and determined 92609 *Therapeutic services for the use of speech-generating device, including programming and modification* (work RVU = 1.50 and 60 minutes intra-service time) requires the same work and intra-service time to perform and recommends crosswalking 925XX2 to 92609. The HCPAC determined that 925XX2 requires 5 minutes more immediate post-service time than 925XX1 to account for the additional number of tests included in the protocol for evaluation of speech sound production, resulting in 5 minutes pre-time, 60 minutes intra-time, and 20 minutes immediate post-time. **The HCPAC recommends a work RVU of 1.50 for CPT code 925XX2.**

925XX3 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)

The HCPAC reviewed the survey results from 151 speech-language pathologists for CPT 925XX3 and determined that the survey respondents appropriately accounted for the time required to perform this service with time components of: 7 minutes pre-time, 120 minutes intra-time and 30 minutes immediate post-service time. However, they did not appropriately value the work compared to the key reference service. Key reference service 96105 *Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour* (work RVU = 1.75 and 4 minutes pre-time, 60 minutes intra-time and 5 minutes post-time) describes 60 minutes of work, whereas 925XX3 requires 120 minutes. The survey respondents did not take into account the timed code when calculating the work RVU. The HCPAC noted that 925XX3 includes the work described in 925XX2 as well as evaluation of language comprehension and expression. ASHA indicated and the HCPAC agreed that the intensity of 925XX3 is different from the first hour of evaluation of speech sound production and the second hour of evaluation of language comprehension. Therefore, the HCPAC recommends a work RVU of 3.36 based on the recommended work RVU for 925XX2 plus the survey median work of 925XX3 ($1.50 + 1.86 = 3.36$). For additional support the HCPAC noted that the recommended work and times for 925XX2 plus 96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (work RVU = 1.86 and 7 minutes pre-time and 60 minutes intra-service time) also equal 3.36, supporting the work and time required to perform this service. **The HCPAC recommends a work RVU of 3.36 for CPT code 925XX3.**

925XX4 Behavioral and qualitative analysis of voice and resonance

The HCPAC reviewed the survey results from 59 speech- language pathologists for CPT code 925XX4 and determined that the survey median work RVU of 1.75 and 5 minutes pre-time, 60 minutes intra and 10 minutes post-service appropriately account for the work and time required to perform this service. The specialty indicated and the HCPAC agreed that 10 minutes immediate post-service time is appropriate to account for the treatment recommendations, prognosis and referrals. The HCPAC noted that this procedure is reported approximately 12% of the time with another code (e.g., swallowing evaluation - 92610) on the same date of service. The HCPAC compared the surveyed code to key reference service 92610 *Evaluation of oral and pharyngeal swallowing function* (work RVU = 1.30 and 7 minutes pre-time, 35 minutes intra-time and 10 minutes post-time) and determined that 925XX4 requires almost twice the time to perform. For additional support, the HCPAC compared the survey code to 96105 *Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour* (work RVU = 1.75 and 4 minutes pre-time, 60 minutes intra and 5 minutes post-time) and determined that these service require the same work and intra-service time. **The HCPAC recommends a work RVU of 1.75 for CPT code 925XX4.**

Practice Expense:

The RUC recommends the direct practice expense inputs as approved by the Practice Expense Subcommittee with no modifications.

The RUC filed the HCPAC Review Board report.

XIV. Research Subcommittee (Tab 33)

Doctor Scott Collins, Chair, provided a summary of the Research Subcommittee report:

The Research Subcommittee reviewed and accepted both the October and November conference call minutes. Doctor Collins also noted that the Subcommittee reviewed the vignettes for CPT codes 47600 *Cholecystectomy* and 47605 *Cholecystectomy; with cholangiography* as requested by CMS. **The Research Subcommittee recommends the vignettes for CPT codes 47600 and 47605 as submitted to accurately describe the typical patient.**

Doctor Collins noted to the RUC that the Research Subcommittee reviewed an alternative PE survey methodology to determine number of blocks for Pathology Consultations, CPT codes 88300-88309. **The Research Subcommittee recommends the methodology utilized to confirm number of blocks. The PE Subcommittee will review the survey data at the April 2013 RUC meeting.**

Doctor Collins explained to the RUC that the American College of Radiology (ACR) submitted a request to crosswalk Ultrasound codes which were identified on the RAW's screen of CMS/Other codes with Medicare utilization of 500,000 or more to recently RUC validated ultrasound codes. Specifically, the ACR proposed to crosswalk CPT codes: 76645 (*Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation*), 76705 (*Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)*), 76770 (*Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete*), 76775 (*Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited*) and 76856 (*Ultrasound, pelvic (nonobstetric), real time with image documentation; complete*). The Subcommittee members agreed that a crosswalk may be inappropriate for these high volume codes which also include high intra service time. In addition, the current time of these codes is based on CMS/Other rather than RUC survey data; therefore, it would be difficult to validate time. The Research Subcommittee initially recommended that the specialty society use the standard survey methodology and present survey data and direct practice expense inputs at the April 2013. However, it was noted that ACR has 11 codes to present at the April meeting, in addition, to 4-5 CPT agenda items. **The Research Subcommittee recommends that the specialty society use the standard survey methodology and present survey data and direct practice expense inputs at the October 2013 RUC meeting, time certain.**

Doctor Collins also reported that the Subcommittee reviewed and discussed a request submitted by ACR to use a targeted sample in addition to random survey sample. It was noted by Doctor Collins that the specialty societies indicated that they were unsuccessful in obtaining a sufficient number of survey responses which was to be presented at the January 2013 meeting. The RUC expressed concern that the societies were having difficulty obtaining a sufficient number of random survey responses for these commonly performed procedures. The society explained that among the 14 codes within this family, there is a combination of base and add-on codes, some of which are complex and not commonly performed procedures. The society also noted that they were delayed launching their surveys due to several CPT issues. The RUC confirmed that the targeted sample will receive the full sample as opposed to only those select few that are not

commonly performed. **The Research Subcommittee recommends the use of the targeted survey sample in addition to the random sample and expects the specialty societies to present both the combined and separated data to the RUC at the April 2013 meeting.**

Doctor Collins discussed the items related to psychotherapy that were reviewed by the Research Subcommittee which included modifications to the survey instrument. Doctor Collins noted that these modifications were similar to those previously approved by the Subcommittee for the April 2012 survey. **The Research Subcommittee recommends modifications to the survey instruments which are consistent with the previously approved and utilized psychotherapy surveys.** Doctor Collins also noted that the Research Subcommittee reviewed and discussed the reference service list for each of the three psychotherapy codes, 90785 *Interactive complexity (List separately in addition to the code for primary procedure)*, 90839 *Psychotherapy for crisis; first 60 minutes* and 90840 *Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)* and suggested a few modifications. **With these modifications, the Research Subcommittee recommends the reference service list as submitted by the specialty societies.** Doctor Collins proceeded to explain that the societies submitted a request for use of a convenience sample. **The Research Subcommittee recommends the use of a convenience sample under the condition that it is proctored.** Lastly, Doctor Collins discussed that the Subcommittee reviewed an alternative proposal to survey CPT code 90785 *Interactive complexity (List separately in addition to the code for primary procedure)*. He explained that this add-on code describes interactive complexity added to certain psychiatric procedures. It does not include intra service time, but rather adds only intensity/complexity and pre and post service time. It was noted that the Subcommittee suggested that the specialty societies consider using an expert panel in conjunction with a RUC survey. **The Research Subcommittee recommends surveying psychotherapy with and without interactive complexity and psychotherapy with an E/M with and without interactive complexity to determine the appropriate increment.**

Doctor Collins reported that the Research Subcommittee reviewed a request submitted by AAO to modify the survey instrument to require attestation from each survey respondent that the survey was completed independently of outside coaching. It was noted that the Subcommittee determined that it would be more appropriate to add this language to the cover memo rather than modify the survey instrument. **The Research Subcommittee recommends development of language to be used by specialty societies in their survey cover memos. The Research Subcommittee will draft this language and share with specialty societies.**

Doctor Collins explained that the Research Subcommittee reviewed www.radiologyinfo.org as a potential source of extant data. It was noted that there was consensus that this site does not meet the extant database criteria and should therefore not be used to support or validate physician work or time. The website is not a database, but rather a source for general background and practical information on various radiology procedures. **The Research Subcommittee does not recommend www.radiologyinfo.org as an extant database.**

Doctor Collins reported that the Research Subcommittee will distribute a survey to all specialty societies to determine how many databases are currently available or in development that may or may not meet our criteria and plans to submit for approval. It

was noted that the Subcommittee reviewed the following questions for the survey to specialty societies:

- 1) **Does your specialty society currently have a database that meets these criteria?**
 - Yes (see Q2)
 - No
 - No, but in development
- 2) **If yes, does your specialty society plan on submitting your database for use and approval to the RUC?**
- 3) **If yes to Q2, when do you expect to submit your request to use the database?**

The Subcommittee recommended two additional questions:

- If your specialty society currently has a database, but it does not meet the above defined criteria, please specify which standards are not met and why.
- Are there databases available that have not been developed by the specialty society? If yes, please list below and provide specific details, if appropriate. **With these modifications, the Research Subcommittee recommends the survey to be approved and disseminated to specialty societies. After completing the solicitation, the Subcommittee will reassess other potential sources of extant data.**

Doctor Collins explained that the Research Subcommittee received a request from the Practice Expense Subcommittee to approve a formal process based on RUC standards to require compelling evidence for increases to practice expense. It was noted that the following modifications for practice expense purposes were suggested:

Delete:

“Comparison to similar services. For example, a similar service consistently has higher times for clinical staff than the PE standards”

Add:

“Evidence that there has been a change in equipment or practice expense cost”

“Evidence that there has been a change in clinical staff type”

“Evidence that previous practice expense inputs were based on one specialty, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data”

With these modifications, the Research Subcommittee recommends the compelling evidence criteria for practice expense inputs.

Doctor Collins also reported that the Practice Expense Subcommittee referred a request to develop a mechanism for societies to provide representative schedules from one or more practices or institutions as supplemental validation of the reported staff and equipment times. It was noted that the logs would be used to verify data. The Research Subcommittee expressed concern that scheduling logs can be problematic in that they may not always reflect time, but rather could be representative of demand. **The Research Subcommittee recommends that if specialty societies are interested in using**

scheduling logs to support recommendations, they must seek and obtain approval from the Research Subcommittee. If the Practice Expense Subcommittee is requesting scheduling logs, the society does not need approval from the Research Subcommittee.

Doctor Collins also explained that the Research Subcommittee discussed strategies to streamline and improve RSL development. The demand for Research Subcommittee review and approval of RSLs has increased over the years. **The Research Subcommittee recommends the creation of a workgroup to address standardization of Reference Service Lists.**

The RUC approved the Research Subcommittee Report.

XV. Relativity Assessment Workgroup (Tab 34)

Marc Raphaelson, MD, provided the Relativity Assessment Workgroup report:

Ad Hoc Work Neutrality Workgroup – Cardiac Device Monitoring

Marc Raphaelson, MD, informed the RUC that the Relativity Assessment Workgroup there was an ad hoc workgroup to review the work neutrality of the cardiac device monitoring codes, which were RUC reviewed in April 2008 and flagged to check the work neutrality in three years. At first view it appeared the volume increased by 22%. However, the Workgroup later discovered that there was an error in the calculation and the volume had increased by 15%. Further, the Workgroup identified that there was an 8% increase in Medicare beneficiaries receiving these services in 2009. Therefore the original work neutrality assumptions differed by only 7%. **The Workgroup determined that due to the complex coding changes that occurred in this family, the specialties' estimations during the formulation of recommendations to the RUC were developed using best faith efforts and are acceptable. The Workgroup recommends removing this family from the new technology list.**

Work Neutrality Review Guidelines

The RAW also discussed how to establish guidelines for further review of retrospective work neutrality issues. **The Workgroup recommends reaffirmation that the RUC and specialty societies work neutrality calculation expectation is a zero change target. If actual work RVUs turn out to be 10% or more greater than the former work RVUs for the family, the family should undergo review by the Relativity Assessment Workgroup.** The RAW may re-assess if new thresholds should be created to re-review codes for which work neutrality adjustments differ from actual claims data.

The cardiac device monitoring family was specifically screened by the RUC to re-review work neutrality. Starting with CPT 2011 codes, AMA staff is reviewing utilization assumptions for all services. In October 2013, data for CPT 2011 and CPT 2012 codes will be available. The RAW should review staff analysis at that time to understand the universe of impacts by family, across two different years of CPT changes.

Review of Action Plans

Doctor Raphaelson indicated that the RAW reviewed 12 action plans and provided recommendations as outlined in the full report. The RUC specifically reviewed CPT code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*, which was identified

through the CMS/Other – Utilization over 500,000 screen, since the specialty society indicated it recommended that this service be resurveyed after review of the thoracentesis codes. The RUC agreed that this service is performed by many specialties and resurveying for the April 2014 RUC meeting is appropriate. The specialty societies are expected to bring a vignette to the Research Subcommittee by October 2013 in order to prepare to conduct the survey.

The RUC approved the Relativity Assessment Workgroup Report.

XVI. Other Issues

There was a referral to the Research Subcommittee to consider excluding low volume codes from being included on Reference Service Lists.

Doctor Levy adjourned the meeting at 6:11 pm on Saturday, January 26, 2013.