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

<u>Drainage of Abscess (Tab 4)</u>
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 the 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 muscoskeletal 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 muscoskeletal 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 muscoskeletal 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 muscoskeletal 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.

<u>Esophagoscopy- January 2013 (Tab 9)</u>
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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 **t**his 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.

<u>Respiratory Motion Management Simulation (Tab 14)</u>
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-serviceand 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 x 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 9358X1to 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.

Arthoplasty (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 osteophytectomy; 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 muscoskeletal 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 muscoskeletal 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 osteophytectomy; 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 muscoskeletal 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 19.61for 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 perform 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 supraselective (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 Pflederer, 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 and10 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, (ACRh); 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, (ACRh)

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.

AMA/Specialty Society RVS Update Committee **Tab 30**
Practice Expense Subcommittee
January 24, 2013

Members Present: Doctors Scott Manaker (Chair), Guy Orangio (Vice Chair), Albert Bothe (CPT Resource), James Blankenship, Joel Brill, Neal Cohen, William Gee, David Han, Timothy Laing, Alan Lazaroff, Geraldine B. McGinty, Margaret Neal, Eileen M. Moynihan, Tye Ouzounian, Howard Lando, Robert Stomel, Sandra Cadena, PhD, ARNP, CNE

I. CMS presentation on PE RVU Methodology

Ryan Howe, Senior Policy Analyst at Center for Medicare & Medicaid Services (CMS) provided the PE Subcommittee with a presentation on practice expense relative value unit methodology.

II. Migration from Film to Digital Imaging Workgroup (PACS)

The Migration from Film to Digital Imaging Workgroup met on December 10, 2012 via conference call to discuss PACS equipment inputs. The Workgroup established that they will identify typical inputs for a PACS system that a physician or group of physicians would own in their nonfacility physician practice. The Workgroup developed a draft list of the individual equipment inputs of the typical PACS system in the nonfacility setting and this draft list will be distributed to specialty societies for comment. The Workgroup plans to revise the inputs based on large buckets, such as modality, i.e. plain film, CT, angiography, echocardiography, etc. In addition the Workgroup determined that additional data was needed to determine if storage costs are a significant variable between services. The Workgroup will request that specialty societies review the list of CPT codes to be included in the migration of film to digital imaging (PACS) and provide estimates of the storage size necessary for the service. The workgroup will then determine if the variability is great enough to justify a range of storage sizes included as PACS system inputs. The Workgroup is also beginning to address changes in clinical staff time, and plans to conclude its recommendations by the April 2013 RUC meeting, if possible.

III. Contrast Imaging Workgroup

During the October 2012 RUC Meeting the PE Subcommittee discussed establishing a workgroup to standardize the contrast related practice expense direct inputs for services that include contrast enhanced imaging studies. The Workgroup met via conference call on Wednesday December 12, 2012. The Workgroup reviewed the inputs from a sample of high utilization CPT codes which involve contrast enhanced imaging, noting that these services are an accurate representation, but differences will need to be examined before a standard can be established. The Workgroup also established that there would need to be several packages to cover all types of contrast imaging services (e.g. CT. MRI, PET, myelography, IVP, aortogram, vena cavagram etc.). Because the American College of Radiology (ACR) has the most experience with contrast enhanced imaging supplies, the ACR will review a representative sample of MRI and CT enhanced contrast imaging studies, including the MRI Brain family of codes being reviewed at the January RUC meeting, and provide potential supply packages for MRI and CT by the time of the April 2013 RUC meeting for review by other interested specialties.

Tab	Title	PE Input Changes (Yes or No)
4	Drainage of Abscess	Yes Minor Modifications
6	Shoulder Prosthesis Removal	No
7	Elbow Prosthesis Removal	No
8	Esophagoscopy Gastroscopy Duodenoscopy (EGD)	Yes Minor Modifications
9	Esophagoscopy	Yes Minor Modifications
10	Chemodenervation of Extremity and Trunk Muscles	Yes Minor Modifications
11	Chemodenervation of Neck Muscles	Yes Modifications/Handout (6461XX only) Yes Minor Modifications (64613X only)
12	Insertion of Anterior Segment Device	No
13	Removal of Cerumen	Yes Modifications/Handout
14	Respiratory Motion Management Simulation	Yes Minor Modifications
15	Optical Endomicroscopy	Yes Minor Modifications
18	Total Body and Selective Head Hypothermia	No PE Inputs
19	Destruction of Premalignant Lesions	Yes Modifications/Handout
20	Arthroplasty	No
21	Thromboendarterectomy	No

22	Selective Catheter Placement	Yes Minor Modifications
23	Percutaneous Thrombectomy	Yes Minor Modifications
24	Laminectomy	No
25	Aqueous Shunt	No
26	MRI – Brain	Yes Minor Modifications
27	Radiation Treatment Delivery-PE Only	Yes Minor Modifications
28	Intravenous Infusion Therapy	Yes Modifications/Handout
29	Chemotherapy Administration	Yes Modifications/Handout
32	Speech Evaluation	No

AMA/Specialty Society RVS Update Committee **Tab 31**
Administrative Subcommittee Report
January 8, 2013
Via E-mail

Members: Doctors Michael Bishop (Chair), J. Allan Tucker (Vice Chair), Dale Blasier, Joel Bradley, Jr., Ronald Burd, John Gage, Anthony Hamm, DC, J. Leonard Lichtenfeld, William Mangold, Jr., Greg Przybylski, and James Waldorf

Primary Care Rotating Seat Eligibility
In April 2012, the Administrative Subcommittee reviewed the Primary Care documentation which specifies that the candidate be defined as a primary care physician by Medicare (i.e. eligible for the primary care bonus). The Subcommittee realized that the current language inadvertently excludes pediatricians as they typically do not treat Medicare patients. The Subcommittee noted that Pediatrics is always defined as primary care and it was not the RUC's intention to exclude Pediatrics. **The RUC recommended that the Administrative Subcommittee review the Primary Care eligibility language in order to refine and include Pediatrics prior to the next election in two years (April 2014).**

> HCERA of 2010
> Effective January 1, 2013 – December 31, 2014, Section 1202 of the Health Care and Education Reconciliation Act of 2010 (HCERA) requires states to pay physicians for primary care services furnished in 2013 and 2014 at a rate that is no less than 100% of the Medicare payment rate. (If greater, the Medicare payment rate in effect in 2009 is to be used.) Limited to physicians with a primary specialty designation of family medicine, general internal medicine or pediatric medicine. Primary care services include those in the Evaluation and Management category under the Healthcare Common Procedure Coding System (HCPCS) used by Medicare, and services related to immunization administration for vaccines and toxoids (CPT codes 90465, 90466, 90467, 90471, 90472, 90473, or 90474). Medicaid managed care plans must make payments to physicians consistent with these minimum payment rates, regardless of the manner in which payments are made by the plans, including capitation payments.
>
> For services furnished from 1/1/2013 through 12/31/2014, provides for 100% federal funding for the difference between the payment rates required under this provision and the level of payment in effect on July 1, 2009. Regular federal matching applies for any payment amounts above the minimum requirement.

January 2013
AMA staff reviewed the RUC Rotating Seat candidate eligibility for the primary care rotating seat. Adding "or Medicaid" to the rotating seat policies and election rules, in regards to physicians providing documentation that they are a primary care physician (receiving the primary care bonus) should sufficiently include pediatricians as eligible to run for the primary care rotating seat. Due to the short time frame for states to implement the Medicaid primary care bonus program and lack of a system such as Medicare's National Provider Identifier (NPI), there are not specific eligibility criteria for physicians to receive the Medicaid primary care bonus. Primary care physicians will attest to providing such services and Medicaid will conduct a retrospective audit. However, by the next rotating seat election (April 2014) the Medicaid primary care bonuses will have been distributed and physicians will be able to provide payment stubs as documentation.

The Administrative Subcommittee determined that adding "or Medicaid" to the RUC primary care rotating seat eligibility criteria was sufficient to include pediatricians, and the American Academy of Pediatrics agreed.

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.

Members Present
Anthony Hamm, DC (Co-Chair), Jane White, PhD, RD, FADA (Alt. Co-Chair), Michael Chaglasian, OD, Scott Collins, MD, Robert Fifer, PhD, CCC-A, Mary Foto, OTR, Emily Hill, PA-C, Stephen Levine, PT, DPT, MSHA, Eileen Moynihan, MD, DPM, and Seth Rubenstein, DPM.

I. CMS Update

Doctor Edith Hambrick delivered the CMS Update. Doctor Hambrick indicated all are welcome to contact and meet with the Agency regarding items for the Proposed Rule for 2014. Doctor Hambrick also indicated that since there was not a change in Administration, Marilyn Tavenner will continue as CMS Acting Administrator.

II. Relative Value Recommendations for CPT 2014:

Speech Evaluation

CPT Code 92506 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 back to the CPT Editorial Panel for further clarification. The HCPAC recommended that 92506 be referred back 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 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, 90 minutes intra 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, 60 minutes intra and 5 minutes post) and determined that 925XX1 requires the 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 and 5 minutes pre, 90 minutes intra and 15 minutes immediate post-service time 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 the 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. **The HCPAC recommends a work RVU of 1.50 and 5 minutes pre, 60 minutes intra and 20 minutes immediate post-service time 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 but 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, 60 minutes intra and 5 minutes post) 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 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 925XX2 plus the survey median work of 925XX3 (1.50 + 1.86 = 3.36). For additional support the HCPAC noted that the work and times of recommended 925XX2 and 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 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 and 7 minutes pre, 120 minutes intra and 30 minutes immediate post-service time 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, 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, 35 minutes intra and 10 minutes post) 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, 60 minutes intra and 5 minutes post) and determined that these service require the same work and intra-service time**. The HCPAC recommends a work RVU of 1.75 and 5 minutes pre, 60 minutes intra-service and 10 minutes post-service time for CPT code 925XX4.**

III. Other Issues

Stephen Levine, PT, DPT informed the HCPAC that the Physical Medicine and Rehabilitation CPT Workgroup will begin at next week's CPT meeting.

The American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA) informed the HCPAC that they met in early January to come to an agreement regarding the representation of the professions of audiology and speech-language pathology on the RUC HCPAC. AAA presented a proposal to ASHA regarding the separate representation of the profession of audiology on the RUC HCPAC. While a compromise was not achieved during this meeting, ASHA agreed to bring AAA's proposal to its Board of Directors for consideration. The respective representatives from AAA and ASHA will meet again following this meeting to discuss further.

AMA/Specialty Society RVS Update Committee **Tab 33**
Research Subcommittee
January 24, 2013

Members: Scott Collins, MD (Chair), M. Douglas Leahy, MD (Vice Chair), Charles Koopmann, Jr, MD, James Georgoulakis, PhD, JD, David Hitzeman, DO, Walt Larimore, MD, Brenda Lewis, DO, Marc Raphaelson, MD, Christopher Senkowski, MD, George Williams, MD, Sandra Reed, MD, Lawrence Martinelli, MD

I. Research Subcommittee October 24, 2012 Conference Call Meeting Report

The Research Subcommittee report from the October 24, 2012 Conference Call is included in Tab 33 of the January 2013 agenda materials for approval by the RUC.

II. Research Subcommittee November 5, 2012 Conference Call Meeting Report

The Research Subcommittee report from the November 5, 2012 Conference Call is included in Tab 33 of the January 2013 agenda materials for approval by the RUC.

III. Review of Vignettes

Cholecystectomy (47600 & 47605)
American College of Surgeons

CPT Codes 47600 *Cholecystectomy* and 47605 *Cholecystectomy; with cholangiography* were identified as part of the CMS Request - NPRM for 2012 screen and surveyed in April 2012.

In the Final Rule for 2013, CMS noted that the AMA RUC agreed that the typical patient undergoing an open cholecystectomy begins with a laparoscopic approach and is then converted to an open procedure for clinical reasons. CMS expressed concern that the vignettes associated with these procedures imply that the work of the failed laparoscopic approach is included in the work of the cholecystectomy. CMS requested that the AMA RUC review the vignettes for these services.

The Research Subcommittee noted that these vignettes along with medical literature were thoroughly reviewed and discussed in November 2011. The Subcommittee continues to acknowledge that nearly all patients are scheduled for a laparoscopic approach and the majority of open procedures would appropriately include the work of the failed laparoscopic approach. It is rare that a cholecystectomy is scheduled as an open procedure. The ACS presented data that this occurs for less than 10% of all cases.

Dr. Hambrick noted that the Agency was concerned that they would be seeing more vignettes for open procedures that are laparoscopic to open conversions. The Subcommittee agreed with the general surgeons that laparoscopic to open conversion is typical for open gallbladder removal cases, but not typical for any other open general surgery procedures. There is no anticipation that the RUC (or CMS) will be seeing other open general procedures with vignettes that are laparoscopic to open conversion. The RUC is aware of CMS' concern and will be diligent in monitoring vignettes.
The Research Subcommittee recommends the vignettes for CPT codes 47600 and 47605 as submitted to accurately describe the typical patient.

IV. Review of Alternative Methodology

Pathology Consultations (88300-88307)
College of American Pathologists

CPT codes 88300-88309 were surveyed for physician work at the April 2010 RUC meeting. These codes were then identified as part of the July 19th 2012 NPRM Screen and surveyed only for direct practice expense at the January 2012 RUC meeting. The RUC submitted the following recommendations for typical number of blocks assumed for anatomic pathology services:

CPT Code 88300: 0
CPT Code 88302: 1
CPT Code 88304: 2
CPT Code 88305: 2
CPT Code 88307: 12
CPT Code 88309: 18

In the Final Rule for 2013, CMS requested public comment regarding the appropriate number of blocks and urged the RUC and medical specialty societies to provide evidence that the number of blocks assumed is indeed typical. In response to this request, CAP along with AAD, ACLA, APC and ASDP contacted over 1,000 laboratories of various sizes and locations to confirm number of blocks typically used for CPT codes 88302-88309 using RUC approved vignettes during November and December 2012. The Research Subcommittee reviewed two survey instruments with cover memos: one for CPT codes 88304-88305 and a second for CPT codes 88302-88309. The Subcommittee noted that each laboratory was asked to review service logs from the previous month and provide data on a minimum of five cases, if available. **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**.

Ultrasound (76645, 76705, 76770, 76775 and 76856)

American College of Radiology

American The 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 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.**

Breast Biopsy (191XX1-191XX6, 1929XX1-1929XX8)

American College of Radiology

The Research Subcommittee reviewed and discussed a request submitted by ACR to use a targeted sample in addition to random survey sample. The ACR, American College of Surgeons and American Society of Breast Surgeons conducted a random RUC survey for the breast biopsy codes which were scheduled to be presented at the January 2013 RUC meeting. The specialty societies were delayed launching their surveys due to several CPT issues and also received an insufficient number of survey responses. The specialty societies intend to present the data collected at the April 2013 RUC meeting and

will also identify members who are familiar with this service and randomly send surveys to those physicians. **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.**

V. Review of Reference Service List, Survey Instrument, Survey Sample

Psychotherapy (90785, 90839 & 90840)
American Psychiatric Association

The Research Subcommittee reviewed and discussed a request from several specialty societies involved in surveying 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)* to modify the survey tools as follows:

- Add "Physician/Healthcare Professional" throughout to be consistent with CPT language
- Allow survey respondents to identify their specialty society. Results will be sorted by specialty
- Defining "organization" in the financial disclosure section and noting that if the survey respondent affirmatively answers any of the questions, they do not have to complete the survey. The Subcommittee recommended that the specialty societies do not allow the survey respondent to continue if they check "yes" to any of the questions.
- Eliminating language regarding hospital and E/R work
- Eliminating moderate sedation section
- Include CPT approved introductory language/guidelines
- Modify Q2 on ZZZ survey instrument regarding time to include definitions for pre, intra and post

The Research Subcommittee recommends modifications to the survey instruments which are consistent with the previously approved and utilized psychotherapy surveys.

The Research Subcommittee reviewed and discussed the reference service list for each of the three codes. The Subcommittee members determined that CPT code 92618 *Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)* should be removed from the RSL for CPT code 90840. In addition, CPT code 99244 *Office consultation for a new or established patient* should be removed from the RSL for CPT code 90839. The Subcommittee suggested that the specialty societies consider combining the RSLs for CPT code 90839 and 90840. The Subcommittee reviewed the RSL for CPT code 90785 and agreed that the previously approved ZZZ RSL which was used to survey psychotherapy in April 2012 should be used for this code. **With these modifications, the Research Subcommittee recommends the reference service list as submitted by the specialty societies.**

The Research Subcommittee discussed the request for a convenience sample. The society would like to administer a survey at an upcoming state leadership meeting scheduled in March 2013. The society will also develop a random survey sample. **The Research Subcommittee recommends the use of a convenience sample under the condition that it is proctored.**

The Research Subcommittee discussed an alternative proposal to survey CPT code 90785. 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. The Research Subcommittee considered the use of an expert panel; however, this alone would not satisfy RUC standards. The specialty societies may 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.

VI. Request to Modify Survey Instrument

Insertion of Anterior Segment Device (6618X1)
Aqueous Shunt (66180 and 66185)
American Academy of Ophthalmology

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. This request was driven after the specialty society detected a thread that encouraged survey respondents to provide higher valuations through the use of specific reference codes while monitoring listserve discussions. The specialty society immediately addressed the issue and collated two data sets. There was consensus that language should be added to ensure surveys are completed independently without external coaching; however, 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.**

VII. Review of Extant Databases

The Research Subcommittee reviewed www.radiologyinfo.org as a potential source of extant data. 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.**

At the October 2012 RUC meeting, the Research Subcommittee was charged with exploring the use and availability of extant databases among specialty societies and how databases that meet our criteria can be incorporated into future recommendations. The Research Subcommittee will solicit 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. 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.

VIII. Practice Expense Subcommittee Items

At the October 2012 RUC meeting, the Practice Expense Subcommittee referred a request to Research to approve a formal process based on RUC standards to require compelling evidence for increases to practice expense. Compelling evidence will be required if a specialty society is requesting an increase over the standard or current PE inputs. The specialty society must present compelling evidence to the PE Subcommittee that the standard or current PE input is not appropriate for the codes in question in writing on the Practice Expense Summary of Recommendation form. The Research Subcommittee reviewed compelling evidence criteria and recommends the following modifications for practice expense purposes:

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.

The Practice Expense Subcommittee also 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. 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.**

IX. Other Business

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 Subcommittee has noted several problems with the current process including lack of comparable codes the specialties can select, especially when an entire family is under review; limited number of high and low valued codes; minimal use of Multi-Specialty Points of Comparison (MPC) codes; etc. **The Research Subcommittee recommends the creation of a workgroup to address standardization of Reference Service Lists.**

AMA/Specialty Society RVS Update Committee **Tab 34**
Relativity Assessment Workgroup
January 24, 2013

Members: Doctors Marc Raphaelson (Chair), Margie Andreae, Amy Aronsky, Michael Bishop, Joel Brill, John Gage, Emily Hill, PA-C, David Hitzeman, Stephen Lahey, Walt Larimore, Larry Martinelli, Gregory Przybylski and Robert Zwolak, MD.

I. Update – Work Neutrality Ad Hoc Workgroup – Cardiac Device Monitoring

The Workgroup met via conference call on November 27, 2012. Doctor Zwolak summarized the history of the Cardiac Device Monitoring services, indicating that in April 2008, the CPT Editorial Panel deleted 11 codes and created 23 new codes to distinguish the work of a programming evaluation from an interrogation evaluation, in person or remotely, performed with different modern devices such as pacemakers and implantable cardioverter defibrillators. At that time the RUC assumed these services would be budget neutral and flagged it to be reviewed after 3 years of data were available. Upon analysis of the utilization data in October 2012, it appeared that there was a 22% increase from 2.2 million work RVUs in 2008 to 2.8 million work RVUs in 2009. The Ad Hoc Workgroup was formed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality. In November, Doctor Zwolak indicated that the Workgroup should determine if these data were accurate, if there were any external clinical rationale for a large increase in these services and if such external clinical changes occurred to determine the impact.

The specialty societies indicated that the physician work has not changed, however there is 1) a growing population of patients receiving these devices for primary prevention when they are pre-Medicare and are now entering Medicare and living longer; 2) technology of the devices has expanded, reducing hospitalizations; and 3) the Guidelines for managing these patients was released at the same time of this new coding structure but were not considered when arriving at the utilization estimates. The development of the new guidelines caused a heightened awareness and education on how to report these services.

The Workgroup's sense was that the information currently provided does not yet fully explain/ substantiate the increase in work RVUs. In November, the Workgroup determined that the specialty societies should provide a revised action plan supported by registry or beneficiary data and/or more information to justify the apparent 22% difference from what the RUC estimated in 2008.

Following the November 27, 2012, conference call, AMA staff worked with ACC and HRS staff to confirm the list of old (2008) and new (2009) CPT codes used to describe cardiac device monitoring in order to obtain data as requested by the Workgroup. Upon review, ACC staff identified an error – two additional codes, 93734 and 93736, were deleted as part of this code family update but had not been included in the work RVU neutrality calculations reviewed at the October 2012 meeting and November 27th call. CPT codes 93734 and 93736 both had significant Medicare utilization in 2008 (238,625 and 514,411 respectively), thus significantly altering determination of the work neutrality increase. **Thus, the increase in work RVUs from the 2008 to the 2009 codes was 15%, not 22% as originally calculated.**

The Workgroup requested that AMA staff collect the Medicare data to determine how many beneficiaries received the services under the old code structure in 2008 and then how many received these services in 2009 under the new code structure. The results indicated that there was an 8% growth in Medicare beneficiaries receiving cardiac device monitoring services from 2008 to 2009. Therefore, the original work neutrality assumptions may differ by only **7%,** if one takes the 15% overall increase in work RVUs minus the 8% increase in Medicare beneficiaries using these services in 2009.

The Workgroup met via conference call on January 8, 2013, and discussed the work neutrality assumption calculation based on the new information provided and reviewed the new action plan from ACC and HRS. The specialty societies stated and the Workgroup agreed that based on 1) the original work neutrality miscalculation, 2) an 8% increase of Medicare beneficiaries receiving these services, 3) industry data that there has been a 9% annual growth of implantation of these devices from 2008 to 2011, and 4) publication of the first comprehensive guidelines in 2008; this family of services work neutrality calculation was actually a 7% or less increase.

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

In October 2012, the Relativity Assessment Workgroup meeting indicated that after the Ad Hoc Workgroup reviewed the work neutrality for this specific family, it should discuss 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.

II. Review Action Plans

Issue	Code	Screen	RAW Recommendation
Lumbar Arthrodesis	22612	Codes Reported Together 75% or More / CMS High Expenditure Procedural Codes	The Workgroup reviewed 3/4 2012 utilization data and same day reporting together combinations to determine if codes 22612, 22630 and new bundled code 22633 are being reported correctly. The Workgroup agreed with specialty societies that the 9 months of utilization data appear to shifting appropriately. However, the Workgroup recommends reviewing the utilization data in 2 years (Oct 2015) to confirm.
Ultrasonic guidance for needle placement	76942	CMS-Other - Utilization over 500,000	The Workgroup agreed with specialty society to survey work and develop PE inputs for April 2014, but to place on LOI for October 2012 for review at the Research Subcommittee to review the survey.
IMRT	77338	PE Services with Stand-Alone Procedure Time	Refer to the PE Subcommittee to review with the other PE Stand-Alone Screen codes.
Implantation and Removal of Patient-Activated Cardiac Event Recorder	33282 33284	CMS Request Final Rule for 2013	The Workgroup disagreed with specialty society to maintain current values. The Workgroup recommends the societies survey for work and develop facility PE inputs for review at the April 2013 RUC meeting.

Issue	Code	Screen	RAW Recommendation
Arteriovenous Anastomosis and Creation of Arteriouvenous Fistula	36818 36819 36820 36821 36825 36830	CMS Request Final Rule for 2013	The Workgroup agreed with the specialty society to survey work and develop PE inputs for review at the October 2013 RUC meeting. The specialty society indicated adding 36820 as well as it is part of this family of services.
Shoulder Arthroscopy	29824 29826 29827 29828	Codes Reported Together 75% or More	The Workgroup determined that most codes in this family were recently reviewed and agree with the specialty society to maintain the current values and review in 3 years (October 2015) of utilization for CPT codes 29824 and 29827 to determine if further review of these related codes are being commonly billed with each other (current utilization data shows these two codes are billed together less than 50% of the time).
Open and Thoracoscopic Surgeries	32440 32480 32482 32663 32668 32669 32670 32671 32672 32673 60520 60521 60522	CMS Request Final Rule for 2013	The Workgroup agreed with the specialty society that open thoracotomy and thoracoscopic procedures have significant differences. These include differences in individual patient characteristics, disease processes and intraoperative work. The Workgroup determined there is no consistent incremental difference attributable to the operative approach alone and there is no way to reliably determine an incremental difference from open thoracotomy to thoracoscopic procedures.
CT Angiography-Abdomen and Pelvis	72191 74174 74175	CMS Request Final Rule for 2013	The Workgroup disagreed with the specialty society that no action is needed. The Workgroup recommends that this family of services be placed on the RUC agenda to re-review the rationale and recommend changes to the times based on the new pre-service packages. The specialty societies will provide rationale for the full RUC to review.
Fluoroscopic Guidance	77001 77002 77003	CMS Request Final Rule for 2013	The Workgroup disagreed with the specialty societies that recommended no action. The Workgroup recommends to survey for work and develop PE inputs 77001 and 77002 to review at the April 2013 RUC meeting. The RUC recently reviewed 77003 (January 2012) and will place it on the LOI so that the RUC may reaffirm this service with 77001 and 77002.
Evoked Potentials and Reflex	95925 95926 95928 95929 95938 95939	CMS Request Final Rule for 2013	The Workgroup agreed with the specialty society that these codes represent two distinct families. The Workgroup reaffirmed that there was an error in the time file for 95938 and the correct times are 10 minutes pre, 20 minutes intra and 10 minutes post. After correcting this error the times for codes 95925, 95926, and 95938 are rational. For the second family, code 95939 was surveyed in April 2011. The Workgroup recommends that codes 95928 and 95929 be resurveyed for work and develop PE inputs for April 2013.

Issue	Code	Screen	RAW Recommendation
In situ Hybridization	88365 88367 88368 88120 88121	CMS Request Final Rule for 2012	The Workgroup agreed with the specialty society to maintain current values but also recommends reviewing 3 more years of data for CPT codes 88120 and 88121 to determine the appropriate utilization has shifted from 88365, 88367 and 88368 to these codes. The Workgroup recommends resurveying the work and develop PE inputs for 88365, 88367 and 88368 for review at the April 2013 RUC meeting.
Negative Pressure Wound Therapy	G0456 G0457	CMS Request Final Rule for 2013	The Workgroup noted that industry individuals developed a CCP to describe the NPWT disposable device, however subsequently withdrew the proposal. The Workgroup recommends that codes G0456 and G0457 be placed on the LOI to allow the any specialties that may have an interest a chance to survey and develop new PE inputs.

III. Other Issues

The following informational items were provided: a list of CPT Editorial Panel Referrals, CPT Assistant Referrals, the progress of Relativity Assessment Workgroup of Potentially Misvalued Services and a full status report of the Relativity Assessment Workgroup (CD only).

Protest Updates: As of October 16, 2012, two protests have been filed against the Jurisdiction E A/B MAC contract that was awarded to Noridian Administrative Services on September 20. CMS has issued a stop work order for the Jurisdiction E contract, while the Government Accountability Office (GAO) reviews the procurement record. During the GAO review period, which is expected to be completed by the end of January 2013, Medicare providers in California, Hawaii, Nevada, and the Pacific territories will continue to file their Medicare claims with the incumbent A/B MAC (Palmetto GBA).

On October 9, 2012, CMS received notification that two protests have been filed against the Jurisdiction 6 A/B MAC contract that was awarded to National Government Services on September 27. GAO completed its review of the procurement record on January 16, 2013, and denied both protests. CMS will now move forward to implement the new contract; CMS expects the implementation process to take five to seven months to complete. CMS and National Government Services will notify affected Medicare providers and other stakeholders of the implementation dates, once these have been finalized. Medicare providers will also be notified concerning any actions that must be taken to support the implementation. Over the next several months, the current Medicare fiscal intermediaries and carriers will continue to administer Medicare payments to providers of Illinois, Minnesota, and Wisconsin.

On October 2, 2012, CMS was notified that a protest has been filed against the Jurisdiction L A/B MAC contract that was awarded to Novitas Solutions, Inc., on September 17. In keeping with federal procurement law, CMS has issued a stop work order for the Jurisdiction L contract, to allow the GAO to review the procurement record. Due to a second protest received on January 8, 2013, the stop work order will be in effect through mid-April. During the GAO review, Novitas will continue to administer Medicare payments to providers in Jurisdiction L (the states of Delaware, Maryland, New Jersey, and Pennsylvania, as well as the District of Columbia) under an existing contract.

On September 18, 2012, CMS received notification that a protest has been filed against the DME MAC C contract award that was made to CGS Administrators, LLC, on August 31. GAO completed its review of the procurement record and denied the protest on December 21, 2012. CMS is moving forward with the implementation of the new contract, which is expected to be completed by April 30, 2013. During this period, CGS Administrators will continue to administer Medicare payments to DME suppliers in Jurisdiction C under an existing contract.

Award Announcements: On September 27, 2012, CMS made a contract award for the Jurisdiction 6 A/B MAC to National Government Services, Inc (NGS). The Jurisdiction 6 A/B MAC administers Medicare Part A and Part B claims for covered services in the states of Illinois, Minnesota, and Wisconsin. This contractor will also administer Medicare billings from home health and hospice providers in thirteen states and five U.S. territories. The current Medicare fiscal intermediaries and carriers for these Medicare workloads (in addition to NGS, Wisconsin Physicians Service and Noridian Administrative Services currently service some of the Medicare claims to be transferred to the new contract) will continue in their responsibilities for several months while CMS and NGS implement the new contract. For more information about the Jurisdiction 6 contract award, use the following hyperlink: Jurisdiction 6 Award Fact Sheet. The contract award has been protested, but GAO denied the protests on January 16, 2013, and CMS and NGS will now implement the new contract over the next five to seven months (see Protest Updates, above).

On September 20, 2012, CMS made a contract award for the Jurisdiction E A/B MAC contract to Noridian Administrative Services. The Jurisdiction E A/B MAC administers Medicare Part A and Part B claims for covered services in the California, Hawaii, and Nevada, as well as the U.S. territories of American Samoa, Guam, and the Northern Mariana Islands. The current A/B MAC for this geographic area, Palmetto GBA, will continue to administer provider claims for up to six months as CMS oversees the transfer of these Medicare contract responsibilities to Noridian Administrative Services. For more information about the Jurisdiction E award, use the following hyperlink: Jurisdiction E Award Fact Sheet. The contract award has been protested (see Protest Updates, above).

On September 17, 2012, CMS made a contract award for the Jurisdiction L A/B MAC contract to Novitas Solutions, Inc. The Jurisdiction L A/B MAC administers Medicare Part A and Part B claims for covered services in the states of Delaware, Maryland, New Jersey, and Pennsylvania, as well as the District of Columbia. For more information about the Jurisdiction L award, use the following hyperlink: Jurisdiction L Award Fact Sheet. The contract award has been protested (see Protest Updates, above).

On August 31, 2012, CMS made a contract award for the Jurisdiction C Durable Medical Equipment (DME) MAC contract to CGS Administrators, LLC. The Jurisdiction C DME MAC administers Medicare supplier claims for DME furnished to program beneficiaries who reside in the states of Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia, as well as Puerto Rico and the U.S. Virgin Islands. The contract award was protested, but GAO has resolved the protest and CMS is now implementing the contract. (see Protest Updates, above). For more information about the Jurisdiction C award, use the following hyperlink: Jurisdiction C Award Fact Sheet

On July 31, 2012, CMS made a contract award for A/B MAC Jurisdiction 5. The Jurisdiction 5 contract award, made to Wisconsin Physicians Service (WPS), covers Iowa, Kansas, Missouri, and Nebraska and also includes Part A providers serviced by WPS under a legacy fiscal intermediary contract. For more information about the Jurisdiction 5 Award, use the following hyperlink: Jurisdiction 5 Award Fact Sheet

Implementation Updates:

Jurisdiction 8 . . . Indiana and Michigan

- The GAO has denied the protest for the AB MAC Jurisdiction 8 contract. As of August 20, 2012, CMS has implemented all Medicare claims processing workloads for Indiana and Michigan into the AB MAC **Jurisdiction 8** contract. Wisconsin Physicians Service Insurance Corporation is the A/B MAC contractor for Jurisdiction 8.

Jurisdiction H . . . Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas

- On March 1, 2012, the GAO denied the protest for the AB MAC **Jurisdiction H** contract. As of mid-November, 2012, CMS has implemented all Medicare claims processing workloads for the seven affected states (Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma and Texas) into the AB MAC Jurisdiction H contract. Novitas Solutions, Inc., is the A/B MAC contractor for Jurisdiction H.

General Status of MAC Procurements: During initial implementation (2005-2010) of MAC procurements, Medicare's claims processing operations have realized significant operational savings from the consolidation of state workloads and the efficiencies gained through integrating Part A and Part B functionality. CMS believes that the efficiency and effectiveness of its contracted Medicare claims operations can be further increased by consolidating some of the smaller A/B MAC workloads to form larger A/B MAC jurisdictions, further reducing the size range among the A/B MACs. In addition, CMS believes that reducing the number of A/B MAC contracts to ten will improve the efficiency and effectiveness of CMS's internal MAC procurement and contract administration processes.

To achieve its ultimate goal of ten A/B MAC contracts, CMS intends to:

- Re-compete five A/B MAC contracts/jurisdictions based on their present area boundaries as the current A/B MAC contracts run their course; and
- Over the next several years, consolidate five pairs of A/B MAC workloads to form five consolidated A/B MAC contracts.

The approximate timing for each consolidation is addressed in the table below, although the exact timing of consolidation actions may be adjusted based on program considerations (contractual status, schedule, etc.).

Former Jurisdiction Designation	New Jurisdiction Designation	Current Contractor	Status
A (DME)	[no change]	National Heritage Insurance Corp.	Fully Implemented NHIC Awarded Rebid, 3/2011
B (DME)	[no change]	National Government Services, Inc.	Fully Implemented NGS Awarded Rebid, 9/2010
C (DME)	[no change]	CGS Administrators, LLC	Recompete Contract Awarded to CGS Administrators, LLC on August 31, 2012. Award protest received; protest denied 12/21/2012; CMS and CGS implementing contract by April 30, 2013.
D (DME)	[no change]	Noridian Administrative Services	Fully Implemented NAS Awarded Rebid, 2/2011
1	E	Palmetto Government Benefits Administrators	Re-compete contract awarded to Noridian Administrative Services on September 20, 2012. Award protest received; a stay of contract performance is in effect, pending GAO review of the procurement.
2	F	Noridian Administrative Services	Consolidated with Jurisdiction 3 forming Jurisdiction F. Contract awarded to NAS 8/2011; contract was fully implemented 2/28/12
3	F	Noridian Administrative Services	Contract awarded to NAS 8/2011. Consolidated with Jurisdiction 2 forming Jurisdiction F; contract was fully implemented 2/28/12
4	H	Pending JH Implementation: TrailBlazer Health Enterprises	Consolidated with Jurisdiction 7 forming Jurisdiction H. Contract awarded to Highmark Medicare Services (now called Novitas Solutions Inc.) on 11/9/11; Award protest received; GAO denied the protest on 3/1/2012. Implementation now underway.
5	G	Wisconsin Physicians Service Insurance	Re-compete contract awarded to WPS on July 31, 2012. To be consolidated with Jurisdiction 6 in several years

		Corporation	(and renamed Jurisdiction G)
6	G	Noridian Administrative Services (NAS - MN A) National Government Services, Inc., (NGS) (WI/IL A) Wisconsin Physicians Service Insurance Corporation (WPS) (MN, IL, WI B)	Contract awarded to NGS 9/27/2012. Award protests received; GAO denied both protests 1/16/2012; contract implementation expected to complete by NLT September 2012.
7	H	Novitas Solutions, Inc.(AR/LA/MS A) Novitas Solutions, Inc.(AR/LA B) Pending JH Implementation: Cahaba (MS B)	Consolidated with Jurisdiction 4 forming Jurisdiction H. Contract awarded to Highmark Medicare Services (now called Novitas) on 11/09/11; Award protest received; GAO denied the protest on 3/01/2012. Implementation now underway.
8	I	Wisconsin Physicians Service Insurance Corporation	Contract awarded to WPS 09/30/2011; Award protest received; GAO denied protest 1/30/2012; CMS has lifted stay of contract performance. Implementation completed on 8/20/2012. To be consolidated with J15 in several years.
9	N	First Coast Service Options, Inc.	Fully Implemented Re-compete expected approximately September of 2012
10	J	Cahaba Government Benefit Administrators	Fully Implemented Re-compete expected approximately January 2013
11	M	Palmetto Government Benefits Administrators	Fully implemented as of June 2011
12	L	Novitas Solutions, Inc. (formerly Highmark	Recompete Contract awarded to Novitas Solutions, Inc. on September 17, 2012. Award protest received; a stay

		Medicare Services)	of contract performance is in effect, pending GAO review of the procurement.
13	K	National Government Services, Inc.	Fully Implemented; to be consolidated with Jurisdiction 14 forming Jurisdiction K. Re-compete RFP-CMS-2012-0005 filed on FEDBIZOPPS at the following hyperlink: Jurisdiction K Request For Proposal
14	K	NHIC, Corp.	Fully Implemented; to be consolidated with Jurisdiction 13 forming Jurisdiction K. Re-compete RFP-CMS-2012-0005 filed on FEDBIZOPPS at the following hyperlink: Jurisdiction K Request For Proposal
15	I	CGS Administrators, LLC	Fully implemented as of 10/17/2011. To be consolidated with Jurisdiction 8 in several years.

For more information on the status of the A/B MAC awards click on the Part A/Part B Medicare Administrative Contractor link to the left. For a map of the DME MAC and Home Health and Hospice jurisdictions click on the Specialty MAC Jurisdiction link to the left.

WPS/Legacy Part A Workload Transfer (West Coast Providers (CA-HI-NV), Southwestern Providers (TX-OK-NM-CO), and Mid-Atlantic Providers (DC-DE-MD-NJ-PA) Formerly Serviced by Mutual of Omaha)

In keeping with CMS policy for assigning providers to A/B MACs, CMS re-assigned three sets of providers from the WPS legacy fiscal intermediary contract to their destination A/B MACs during calendar 2010 and early 2011. Please see the Medicare Learning Network article link below for more detail.

This site is updated regularly. All major website changes occurring within the last 30 days will be logged here for easy reference.

Downloads

- SE1016 [PDF, 67KB] http://www.cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/Spotlight.html

AMA/Specialty Society RVS/Update Committee **Tab 26**
Facilitation Committee #3
January 25, 2013

Members Present: David Hitzeman (Chair); Michael Bishop; Joel Bradley; Emily Hill; Gregory Przybylski; Jonathan Myles; Marc Raphaelson; James Waldorf

Prior to beginning the discussion, AMA staff clarified two key points relating to the discussion that occurred during the RUC's deliberations. First, the RUC database incorrectly lists the meeting date and physician time for CPT code 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material*. AMA staff confirmed that the correct physician time for 70551 is 28 total minutes, with a CMS/Other source. Additionally, the Facilitation Committee clarified that 70551 is typically done in the inpatient setting (51.9%). There was confusion at the table, because the data for the Global service was being reviewed, rather than the physician component only (26), which is by far the typical scenario.

70551 ***Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material***
With the above understanding, the Facilitation Committee reviewed several comparator CPT codes and agreed that the current value of 1.48, lower than the 25th percentile, is appropriate for this code. The Committee reviewed CPT code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.40, 5/18/5) and agreed that with identical times the two services should be valued similarly. The Committee also reviewed 70496 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 1.75, 8/20/10) and agreed that the reference code should be valued higher as it has 5 additional minutes of intra-service time compared to the surveyed code. **The Facilitation Committee recommends a work RVU of 1.48, with pre-service time= 5 minutes, intra-service time= 18 minutes, and post-service time= 5 minutes for CPT code 70551.**

70552 ***Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)***
The Facilitation Committee noted that the RUC did not previously discuss this code because the family was sent to facilitation due to 70551 being voted down. The RUC reviewed several comparator CPT codes and agreed that the current value of 1.78, lower than the 25th percentile, is appropriate for this code. The Committee compared the surveyed code to similar code 73222 *Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)* (work RVU= 1.62, 5/20/8) 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 Committee 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, 8/15/10) and noted that while the reference code has less intra-service time, the survey respondees indicated that this code is a more intense service than 70552 and should be valued higher. **The Facilitation Committee recommends a work RVU of 1.78, with pre-service time= 5 minutes, intra-service time= 20 minutes, and post-service time= 7 minutes 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 Facilitation Committee noted that the RUC did not previously discuss this code because the family was sent to facilitation due to 70551 being voted down. The RUC reviewed several comparator CPT codes and agreed that the current value of 2.36, lower than the survey median, is appropriate for this code. The Committee compared the surveyed code to 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, 8/15/10) 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, 7.5/24/10) was reviewed and the Committee agreed that 70553 is a more intense procedure and should be valued slightly higher. **The Facilitation Committee recommends a work RVU of 2.36, with pre-service time= 7 minutes, intra-service time= 25 minutes, and post-service time= 7 minutes for CPT code 70553.**

Finally, the Committee reviewed the incremental increase between the MRI pelvis without contrast (72195, work RVU= 1.46), with contrast (72196, work RVU= 1.73) and with and without contrast (72197, work RVU= 2.26) and agreed that the level of increase was similar to the recommended increase between these MRI brain codes. Therefore, the Facilitation Committee agreed that the family of services are accurately valued at the current work RVUs.

Members Present: David Hitzeman (Chair); Michael Bishop; Joel Bradley; Emily Hill; Gregory Przybylski; Jonathan Myles; Marc Raphaelson; James Waldorf; Jennifer Wiler

The Facilitation Committee discussed several issues regarding these families of EGD and Esophagoscopy codes.

Pre & Post Times

The members discussed the variability of pre and post service time between the new surveys at this meeting and the previous surveys of the Esophagoscopy codes performed in October 2012. The Esophagoscopy codes surveyed at the October 2012 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. This resulted in standardized pre and post service times. For the current presentation, each service was fully surveyed, including pre and post time. The Committee agreed with the Specialty Society that the best approach would be to use the surveyed time for this series of codes, rather than arbitrarily deriving times from previous surveys.

Work Value Methodology

Second, the Facilitation committee discussed the standardized methodology to arrive at these work values. The Committee used two 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 was recommended or the survey 25th percentile, whichever was lower.

Endoscopy Rule Explained

Endoscopies in the same family (i.e., those that share the same base procedure) are reimbursed according to special rules:

- The endoscopic procedure with the highest payment schedule amount is reimbursed at the highest level.
- The reimbursement amount for the base procedure is subtracted from all endoscopic procedure(s) performed on that date except for the procedure with the highest payment schedule amount

Base Code Valuation

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

The Facilitation Committee reiterated that the valuation of the base code 43235 is critical to this family of codes as it is used as the base code for the incremental work in the family of EGD codes. Therefore, the Committee agreed with the Specialty Society that since the current value, 2.39, is already lower than the survey 25th percentile, a direct crosswalk to a similar code was warranted. The Committee reviewed CPT code 31579 *Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy* (work RVU= 2.26, 15/15/15) and agreed that with similar physician work and identical intra-service time the work RVUs should be identical as well. To validate this work RVU the Committee reviewed MPC code 52000 *Cystourethroscopy* (work RVU= 2.23, 17/15/10) and MPC code 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, 24/15/10). The members agreed that with identical intra-service times and comparable physician work, the recommended work RVU of 2.26 is appropriate. **The Facilitation Committee recommends a work RVU of 2.26 for CPT code 43235.**

Resurvey of 43246 and 43251 for April 2013

The median survey intra-service time for 43246 *Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube* was 23 minutes, 8 minutes greater than the intra-service time for the base EGD code 43235 of 15 minutes. This led the Facilitation Committee to question the validity of the survey, in view of the previous intra-service time of 38 minutes when this code was surveyed in the 2005 Five-Year review. The expert panel was unable to explain the survey results. **Therefore, the Facilitation Committee recommends resurveying code 43246 for presentation at the April 2013 RUC meeting.**

The median survey intra-service time for 43251 *Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* was 20 minutes. Code 43235, the EGD base code which was surveyed and presented at this meeting, has 15 minutes of intra-service time, resulting in a time differential of 5 minutes between these procedures. The corresponding esophagoscopy equivalent is 43217 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* when surveyed and presented at the October 2012 RUC meeting has 30 minutes of intra-service time while the base esophagoscopy code 43200 has 15 minutes of intra-service time resulting in a time differential of 15 minutes. This led the expert panel to question the validity of the survey and whether the median intra-service time reported by the survey participants was correct. **Therefore, the Facilitation Committee recommends resurveying code 43251 for presentation at the April 2013 RUC meeting.**

The Facilitation Committee reviewed and accepted the direct practice expense recommendations for these series of codes as modified by the Practice Expense Subcommittee.

Project Overview
Medicare Physician Fee Schedule (PFS):
Development of a Model for Valuing the Work Relative Value Units (RVUs)

Purpose: The Centers for Medicare & Medicaid Services (CMS) has asked RAND to develop a validation model for the work component of the Medicare physician fee schedule and to test the model using a set of representative test codes.

Background: In 2012, an estimated $87 billion in allowed charges will be paid under the physician fee schedule for services furnished to fee-for-service Medicare beneficiaries by physicians and other practitioners who bill independently for their services. The physician fee schedule uses relative value units (RVUs), a conversion factor ($34.04 per RVU in 2012), and various adjustments to determine the reimbursement for a given service. The relative resources that go into determining the RVUs for a given service are broken down into physician work, practice expense and malpractice expense. The work component accounts for the practitioner's effort through measures of time and intensity (i.e., cognitive effort and judgment, technical skill and physical effort, and stress due to potential patient risk) associated with providing a service.

It is important that RVUs be accurately set under the physician fee schedule to assure access to medically appropriate services. If a procedure is overpriced, Medicare is wasting resources by paying more than it should and an incentive is created to provide unnecessary services. If a procedure is underpriced, it may be hard to obtain and lead to potential access problems. Moreover, systematic over- or underpricing of procedures furnished by particular specialties can distort overall compensation levels and affect the specialty choices made by new physicians.

Under the current process for updating the relative value units (RVUs) for physician work, CMS considers recommendations for the American Medical Association's Specialty Society Relative Value Update Committee (RUC), the Medicare Payment Advisory Commission (MedPAC) and others. Section 3134 of the Affordable Care Act requires that CMS establish a process to validate RVUs of physician fee schedule services and explicitly authorizes CMS to conduct the validation through surveys, other data collection activities, studies, or other analyses that would facilitate validation.

Study Approach: During this two-year project, RAND will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. The model design will be informed by the statistical methodologies and approach used to develop the initial work RVUs and to identify potentially misvalued procedures under current RUC and CMS processes. RAND will use a representative set of CMS-provided codes to test the model. RAND will consult with a technical expert panel on model design issues and the test results.

RAND Project Contacts

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RUC

Update – Jan. 2013

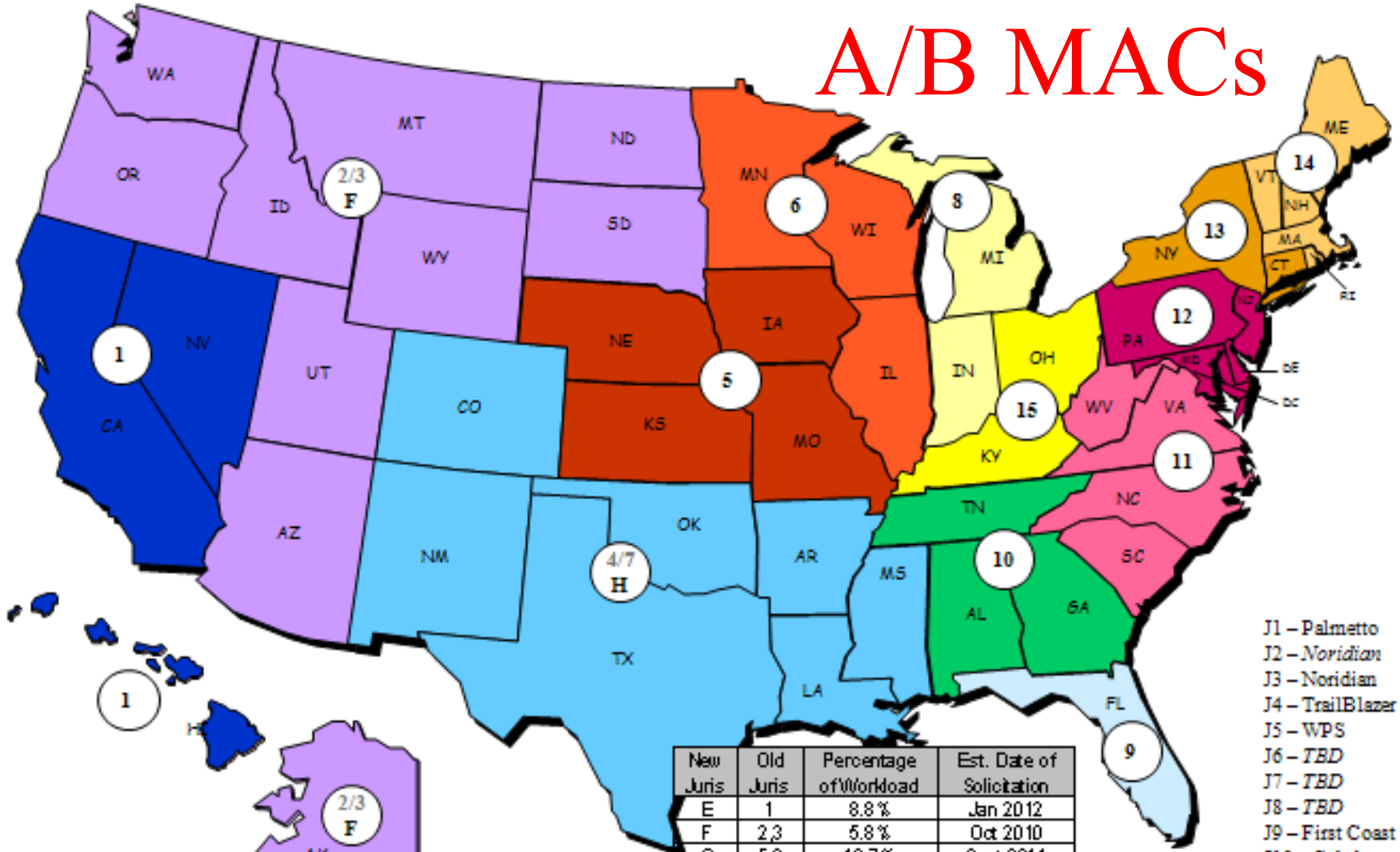
Richard W. Whitten, MD, FACP

Contractor Medical Director - Medicare

dick.whitten@noridian.com

Contractor Updates

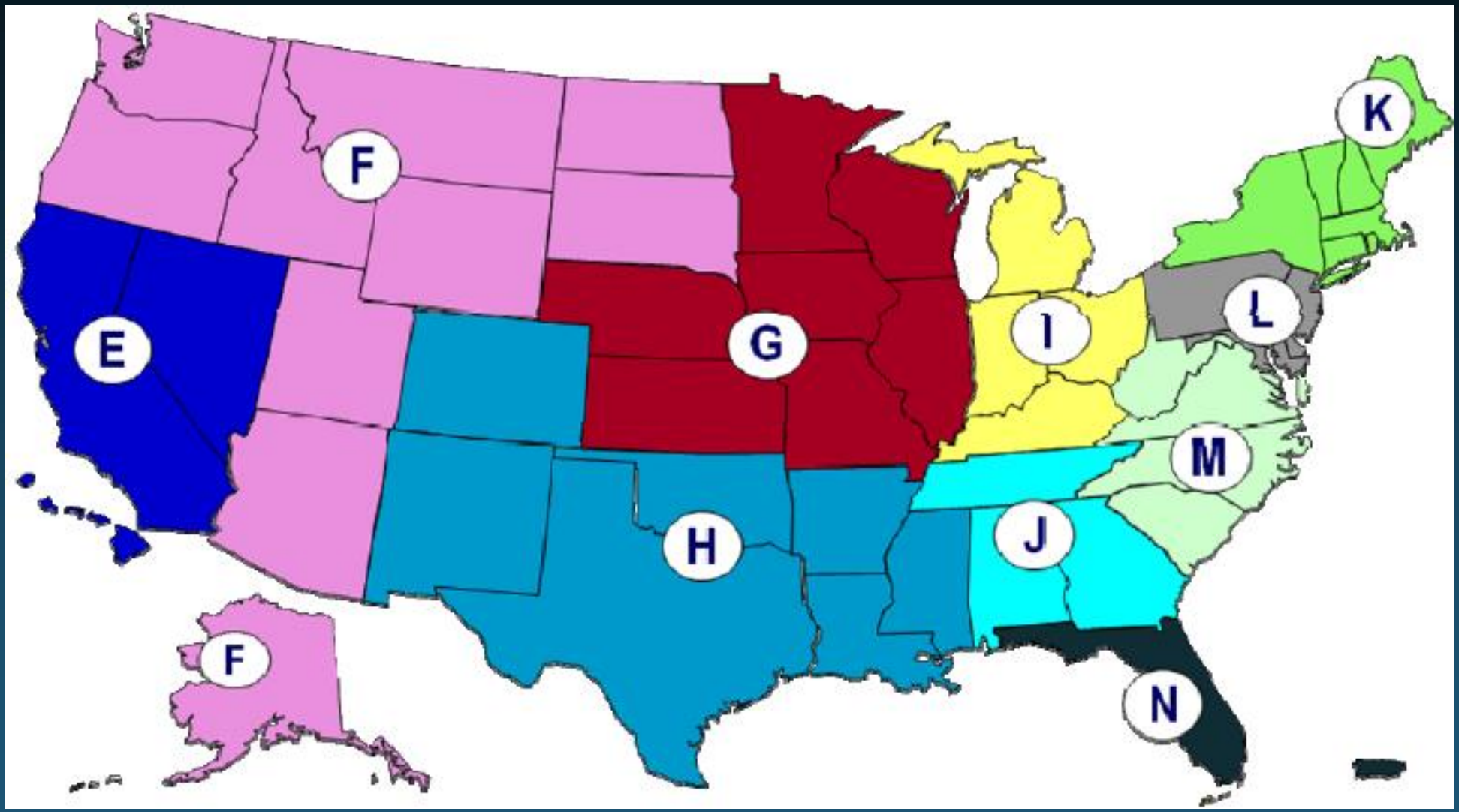
A/B MACs



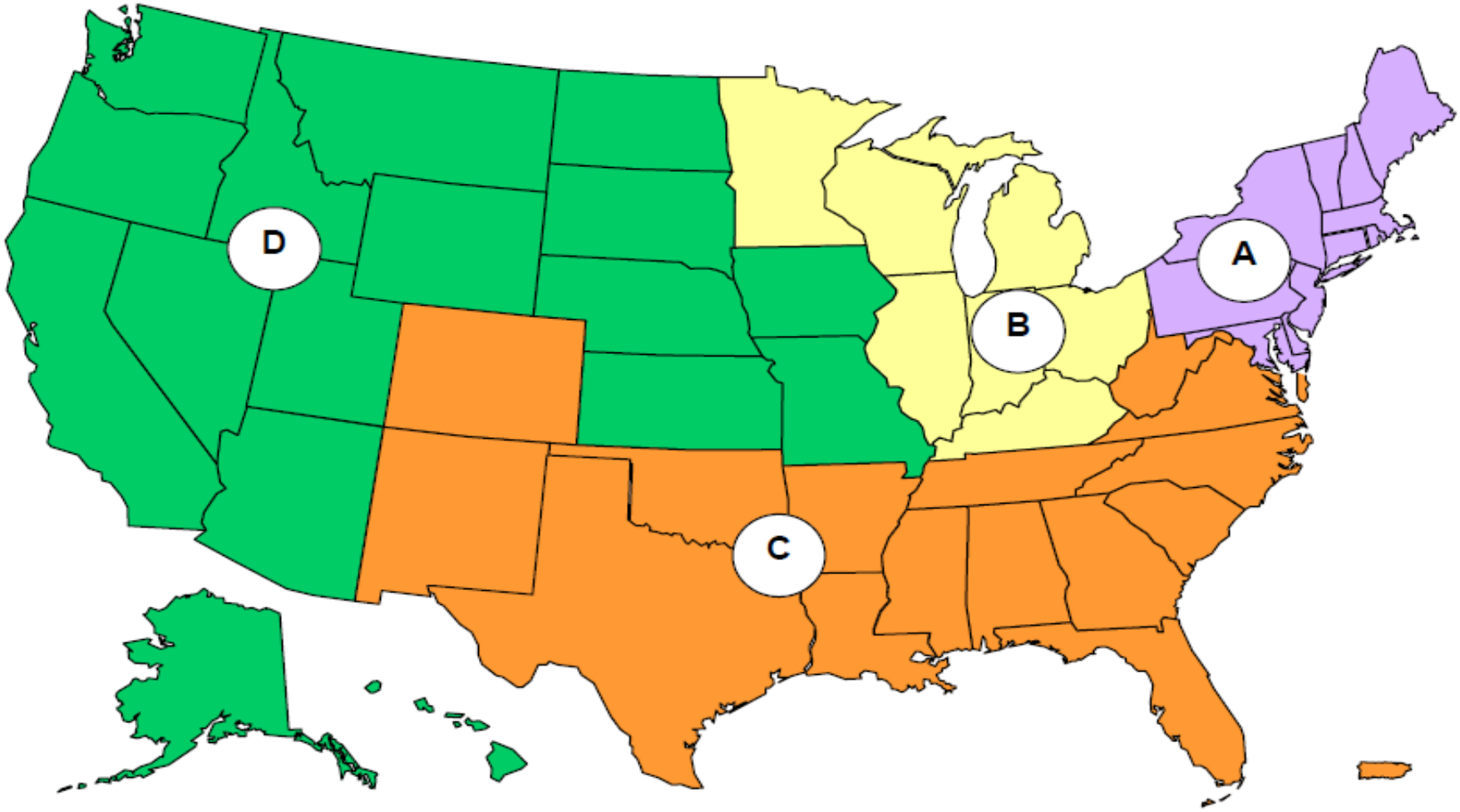
New Juris	Old Juris	Percentage of Workload	Est. Date of Solicitation
E	1	8.8 %	Jan 2012
F	2,3	5.8 %	Oct 2010
G	5,6	12.7 %	Sept 2011
H	4,7	13.2 %	Nov 2010
I	8,15	11.8 %	July 2014
J	10	7.3 %	Jan 2013
K	13,14	12.3 %	Mar 2012
L	12	10.9 %	Mar 2012
M	11	8.9 %	May 2014
N	9	8.2 %	Sept 2012

J1 – Palmetto
J2 – *Noridian*
J3 – Noridian
J4 – TrailBlazer
J5 – WPS
J6 – *TBD*
J7 – *TBD*
J8 – *TBD*
J9 – First Coast
J10 – Cahaba
J11 – Palmetto
J12 – Highmark
J13 – NGS
J14 – NHIC
J15 – *CIGNA*

A/B MACs



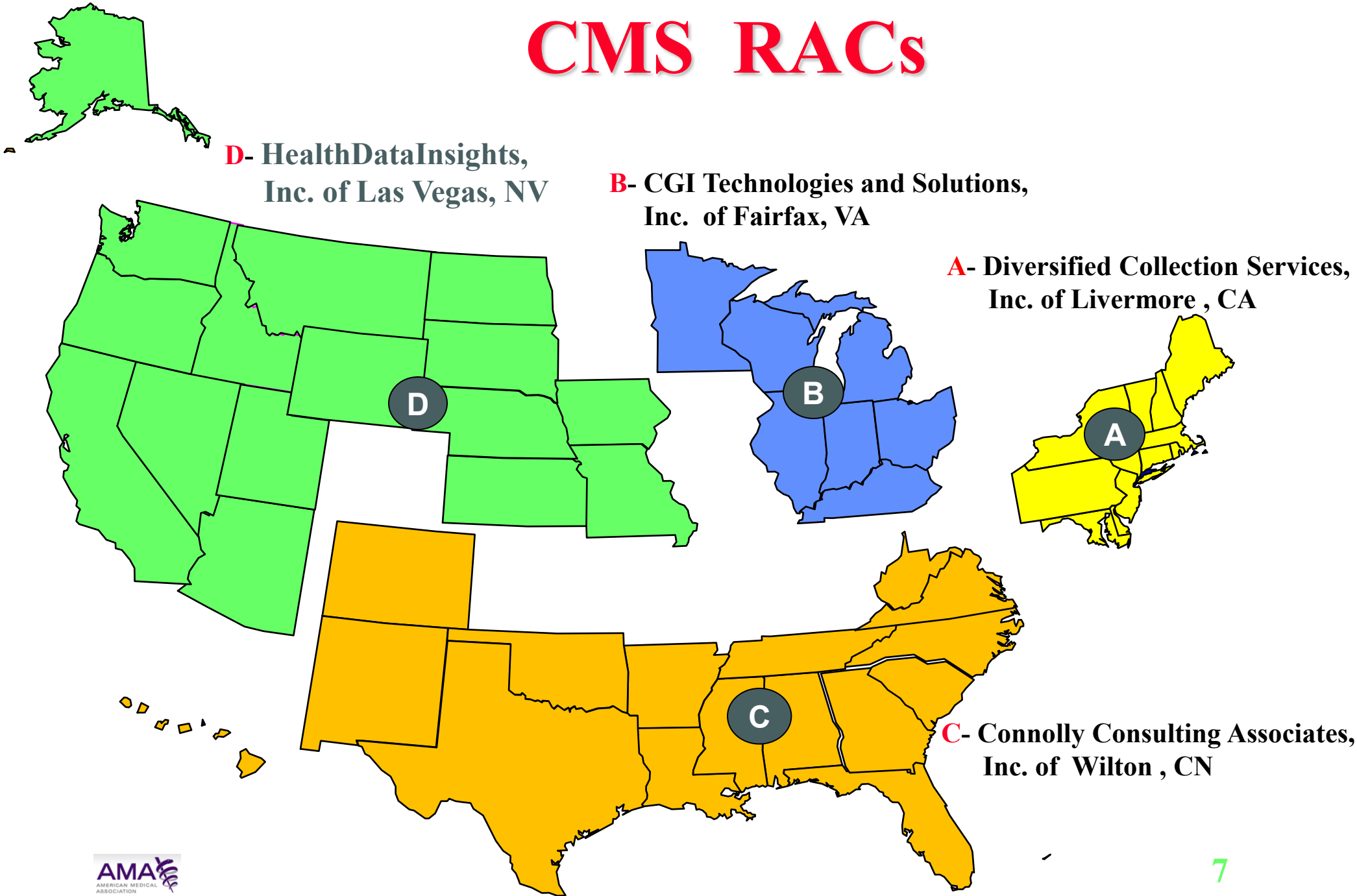
Durable Medical Equipment Medicare Administrative Contractor Jurisdictions



Separate Issue for DMEPOS

- **§ 6407 of Affordable Care Act**
  - 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


D- HealthDataInsights, Inc. of Las Vegas, NV
B- CGI Technologies and Solutions, Inc. of Fairfax, VA
A- Diversified Collection Services, Inc. of Livermore , CA
C- Connolly Consulting Associates, Inc. of Wilton , CN
D
B
A
C

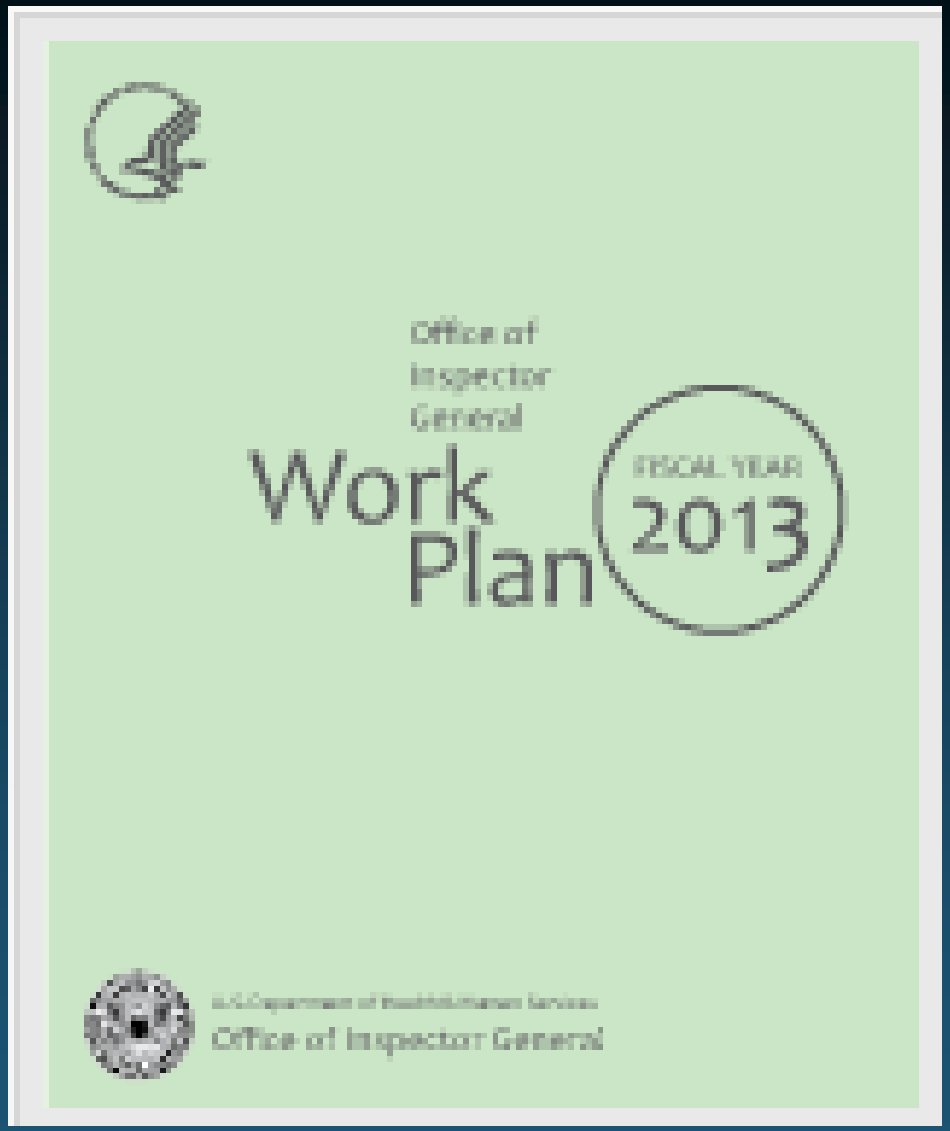
Assistance with a ZPIC audit:

http://www.zpicaudit.com/tag/zpic/

ZPICs

Zone	Geographic Area
1	American Samoa, California, Guam, Hawaii, Mariana Islands, Nevada
2	Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
3	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin
4	Colorado, New Mexico, Oklahoma, Texas
5	Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia
6	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
7	Florida, Puerto Rico, U.S. Virgin Islands

http://www.zpicaudit.com/


Office of
Inspector
General
Work
Plan
FISCAL YEAR
2013
Office of Inspector General

http://oig.hhs.gov/reports-and-publications/workplan/index.asp

Contractor CMDs

"LCD Writers" now meeting regularly

13.7 - LCD Development Process
(Rev. 71, 04-09-04)

When a new or revised LCD is needed, contractors do the following:

Contact the CMD facilitation contractor, other contractors, the local carrier or intermediary, the DMERC (if applicable), the Medicare Coverage Database or QIOs (formerly PROs) to inquire if a policy which addresses the issue in question already exists;

Adopt or adapt an existing LCD, if possible; or

Develop a policy if no policy exists or an existing policy cannot be adapted to the specific situation.

The process for developing the LCD includes developing a draft LCD based on review of medical literature and the contractor's understanding of local practice.

A. Multi-State Contractors

A contractor with LCD jurisdiction for two or more States is strongly encouraged to develop uniform LCDs across all its jurisdictions. However, carriers shall continue to maintain and utilize CACs in accordance with §13.8 below.

13.8.1.1 - Purpose of the CAC
(Rev. 71, 04-09-04)

The purpose of the CAC is to provide:

A formal mechanism for physicians in the State to be informed of and participate in the development of an LCD in an advisory capacity;

A mechanism to discuss and improve administrative policies that are within carrier discretion; and

A forum for information exchange between carriers and physicians.

Carriers shall clearly communicate to CAC members that **the focus of the CAC is LCDs and administrative policies** and not issues and policies related to private insurance business. The CAC is not a forum for peer review, discussion of individual cases or individual providers. While the CAC shall review all draft LCDs, the final implementation decision about LCDs rests with the CMD. The CMD jointly develops the agenda with the co-chair representing the CAC to include concerns about LCDs and local administrative issues.

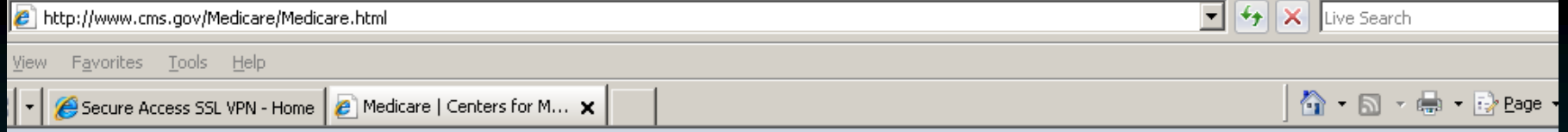
13.11 - LCD Reconsideration Process
(Rev. 71, 04-09-04)

Contractors who have the task of developing LCDs shall have an LCD Reconsideration Process in accordance with the following instructions.

A. Purpose
The LCD Reconsideration Process is a mechanism by which interested parties can request a revision to an LCD.

B. Scope
The LCD Reconsideration Process is available only for final LCDs. The whole LCD or any provision of the LCD may be reconsidered.

C. General
Contractors shall respond timely to requests for LCD reconsideration. In addition, contractors have the discretion to revise or retire their LCDs at any time on their own initiatives.



CMS.gov
Centers for Medicare & Medicaid Services

Learn about your healthcare options

contractor medical director Search

Medicare

People with Medicare, family members, and caregivers should visit Medicare.gov, the Official U.S. Government Site for People with Medicare, for the latest information on Medicare enrollment, benefits, and other helpful tools.

Medicare - General Information

Medicare Program - General Information

Beneficiary Notices Initiative (BNI)

Medicare Approved Facilities/Trials/Registries

Medicare Health Support (formerly CCIP)

Medicare Contracting

Medicare Contracting Reform

Contractor Provider Customer Service Program - General Information

Contractor Provider Customer Service Resources

Medicare Fee-for-Service

CMS News

People with Medicare Save Over $4.1 Billion On Prescription Drugs Thanks To The Health Care Law

Obama administration issues new rules to cut red tape for doctors and hospitals, saving up to $9 billion

Command Center Speeds Up Anti-Fraud Efforts

CMS Launches New Interactive Map with

« Back to Indexes

Contacts For Part B - Medicare Administrative Contractor (MAC - Part B) Alphabetical Index

Use the alphabetical links above the results table to jump to Contractors starting with that letter.

Contacts Alphabetical Index Results [58 Contacts]

Select a link: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Note: Only displaying linked letters for which there are records.

Page 1 of 3 Enter Pag Go to page First Prev 1 2 3 Next Last View Items Per Page: 25

	CONTRACTOR	MEDICAL DIRECTOR	STATE(S) COVERED
C	Cahaba Government Benefit Administrators®, LLC (10102, MAC - Part B) P.O. Box 13384 Birmingham, AL 35202-3384	Greg McKinney, MD, MBA, Senior Contractor Medical Director	AL
	Cahaba Government Benefit Administrators®, LLC (10202, MAC - Part B)	Greg McKinney, MD, MBA, Senior	

Thank you. Comments/questions welcome:

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Washington Update
RVS Update Committee

Sharon McIlrath

January 25, 2013

Recap: 112th Congress

- 1 of the least productive ever
- 33 House votes on ACA repeal
  - Made technical corrections impossible
- No budget passed
- Kicked the can on:
  - SGR Repeal
  - Deficit reduction
  - Budget and other issues.

Temporary Reprieve (American Taxpayer Relief Act)

- Enacted New Years Day
- Physician provisions:
  - Averted a 26.5% cut in Medicare CF
  - Extended 1% work GPCI floor
  - Did not stop other 2013 payment changes
  - Expanded PQRS to include clinical data registries
  - 2 month delay in sequester
    - 2% cut in Medicare payments
    - Higher cuts for NIH, public health, etc.

SGR Offsets

- Half of the $25 billion cost from hospitals.
- Includes coding change adjustment.
- Imaging utilization volume assumption modified.
- Statute of limitations for recouping overpayments increased from 3 to 5 years.
- ACA unexpended co-op funds eliminated.
- Did not include:
  - Elimination of increased Medicaid payment for primary care
  - Reductions in HOPD visit payments.

The Road Ahead

- Feb: President's budget submitted.
- March: sequester starts; continuing resolution for 2013 ends.
- April: budget bills due.
- May: 3-month debt ceiling deal expires.
- Focus will be on deficit reduction
- Entitlement reform will be on the table.

Entitlement Reform & SGR

- CBO says repeal costs $250 to $300 billion.
- Only way to find that sort of money is in a bill that makes other large scale changes.
- 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 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 $ 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 provides 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.

SGR Transition Plan Cont.

- Nothing is set in stone.
- Has been vetted with a task force of state and specialty medical representatives. Shared with state and specialty execs.
- Have been talking to CMS and key Hill committee staff.
- Has been a lot of interest but need more concrete examples and evidence that physicians would participate in such alternatives.
- In addition to higher updates, physicians in these models could share in any savings from the models.
- 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; 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

- Data:
  - who can get it, for what purposes, when,
  - how to ensure accuracy, fairness and utility.
  - important for Physician Compare, VBM and physician feedback reports.
- 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 at highest levels of CMS and HHS.
  - Many specialties didn't sign our group letter and most other health care providers don't want further delays.

Regulatory Agenda Cont.

- 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.

AMA/Specialty Society RVS Update Committee
Facilitation Committee #1
Drainage of Abscess

Members Present: Brenda Lewis, DO (Chair), James Blankenship, MD, William Gee, MD, Charles Koopmann, MD, Alan Lazaroff, MD, Larry Martinelli, MD, Sandra Reed, MD, Joseph Schlecht, DO, George Williams, MD, Jane White, PhD, RD, FADA, LDN

The Facilitation Committee discussed the physician work and time associated with CPT Codes 100XX1 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); soft tissue (eg, extremity, abdominal wall, neck), percutaneous,* 4900X2 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous,* 4900X3 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous* and 4900X4 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* and their appropriate work RVU relative to similar services, after the work RVU of 3.00 presented by the specialty societies for 100XX1 was rejected by the RUC. The following is a summary of the facilitation committee's recommendation:

	100XX1	**4900X2**	**4900X3**	**4900X4**
Pre-Eval	21 minutes	35 minutes	35 minutes	35 minutes
Pre-Positioning	5 minutes	5 minutes	5 minutes	5 minutes
Scrub, Dress & Wait	5 minutes	5 minutes	5 minutes	5 minutes
Intra-Service	30 minutes	40 minutes	40 minutes	45 minutes
Post-Time	20 minutes	20 minutes	20 minutes	20 minutes
Total Time	**82 minutes**	**105**	**105**	**110**
RVU	**3.00**	**4.25**	**4.25**	**4.50**

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

The RUC initially reviewed this code and determined that a work RVU of 3.00 overstated physician work. The RUC compared 100XX1 to 10180 *Incision and drainage, complex, postoperative wound infection* (work RVU=2.30) and initially agreed that physician work and times were similar. However, after further review, the committee members came to a consensus that CPT code 10180 should not be used since time is based on Harvard, there is no imaging and there is variation in global periods. The committee also pointed out that this code may be misvalued and should be referred to RAW for further review. The committee also reviewed physician time and determined that pre-service package 1b- Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care) was more appropriate

compared to 2b- Difficult Patient/Straightforward Procedure (With sedation/anesthesia). The committee agreed that an additional 2 minutes for pre-service evaluation and 4 minutes for pre-service positioning to account for skin preparation and positioning used for ultrasound is appropriate. In addition, the committee agreed with the specialty society's recommendation of 20 minutes for post-service time. Physicians spend time educating nursing staff, family members and the patient on maintaining and caring for the catheter, in addition to typical post service work activities, such as reviewing and interpreting images, completing orders and reports and assessing vital signs.

The committee determined that a work RVU of 3.00, the survey 25th percentile appropriately accounts for the physician work. 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 100X1 was greater. For additional support, the committee reviewed CPT codes 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU=3.12), 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 these services were similar in physician work and intensity. **The facilitation committee recommends a work RVU of 3.00, the survey 25th percentile for CPT code 100XX1 and the following times:**

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

The facilitation committee reviewed the survey results for CPT code 4900X2 and determined that a work RVU of 4.25, the survey 25th percentile appropriately accounts for the physician work and time. The committee noted that this service was previously reported using a combination of 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 agreed that pre-service package 2b- Difficult Patient/Straightforward Procedure (With sedation/anesthesia) with adjustments of 2 minutes for pre-service evaluation and 4 minutes for pre-service positioning are appropriate for imaging. 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 facilitation committee 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 facilitation committee reviewed the survey results for CPT code 4900X3 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. 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 agreed that pre-service package 2b- Difficult Patient/Straightforward Procedure (With sedation/anesthesia) with adjustments of 2 minutes for pre-service evaluation and 4 minutes for pre-service positioning are appropriate for imaging. 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 facilitation committee 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 facilitation committee reviewed the survey results for CPT code 4900X4 and determined that a work RVU of 4.50, the survey 25th percentile appropriately accounts for the physician work and time. 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 al*ong 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 agreed that pre-service package 2b- Difficult Patient/Straightforward Procedure (With sedation/anesthesia) with adjustments of 2 minutes for pre-service evaluation and 4 minutes for pre-service positioning are appropriate for imaging. 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 facilitation committee recommends a work RVU of 4.50, for CPT code 4900X4.**

Tracking Number	Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey RVW 25%	Pre-Service Package	Pre	Intra	Post	Total	IWPUT
I1	43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed	2.39	2.26	3.00	2.59	1b	27	15	12	54	0.097
I2	43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.92	2.57	3.62	3.21	1b	27	20	15	62	0.085
I5	43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	2.87	2.56	3.36	3.00	1b	27	15	12	54	0.117
I7	43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube, or catheter	2.59	2.59	4.25	3.50	2b	33	30	15	78	0.053
I9	43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices	4.56	4.37	4.89	4.37	2b	41	30	20	91	0.103
I10	43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices	5.04	4.50	4.90	4.50	2b	41	30	20	91	0.107
I11	43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)	3.18	3.18	4.13	3.58	2b	33	23	15	71	0.097
I12	43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	4.32	**resurvey**	4.55	4.24	2b	41	23	15	79	0.136
I13	43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body	3.38	3.27	4.50	3.98	2b	23	30	15	68	0.082
I14	43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire	3.15	3.01	4.10	3.64	1b	27	20	15	62	0.107
I15	43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.90	2.77	4.07	3.36	1b	27	20	15	62	0.095
I17	43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.20	3.07	3.50	3.25	1b	24	20	14	58	0.115
I18	43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.69	**resurvey**	4.00	3.69	2b	28	20	12	60	0.137
I19	43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	NEW	3.06	4.00	3.66	1b	27	30	20	77	0.069
I22	43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	4.81	4.20	4.93	4.20	2b	41	30	20	91	0.097
I24	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	5.50	4.25	5.10	4.25	2b	41	45	15	101	0.068
I21	4325X4	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	NEW	5.25	6.90	5.25	2b	38	45	20	103	0.089
I16	4326X7	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	NEW	4.45	4.98	4.45	2b	38	30	20	88	0.099
I23	4326X8	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	NEW	4.40	5.20	4.40	2b	41	40	20	101	0.078
I25	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)	NEW	4.39	5.75	4.39	2b	41	45	15	101	0.071

Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT	Facilitation Committee Rationale
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed	2.39	2.26	3.00	2.59	1b	27	15	12	54	0.097	The Facilitation Committee agreed that a direct crosswalk to CPT code 31579 Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy (work RVU= 2.26, 15/15/15), lower than the current value and below the survey 25th percentile, is appropriate. This value is substantiated by MPC code 52000 Cystourethroscopy (work RVU= 2.23, 17/15/10) and MPC code 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, 24/15/10).
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.92	2.57	3.62	3.21	1b	27	20	15	62	0.085	The Facilitation Committee agreed that the previously approved Esophagoscopy increment between the diagnostic and injection code (0.31) is appropriate. Therefore 0.31 was added to base code 43235 (recommended work RVU=2.26) for a recommended work RVU of 2.57, lower than the current value and below the survey 25th percentile. This value is substantiated by MPC code 51102 Aspiration of bladder; with insertion of suprapubic catheter (work RVU= 2.70, 25/20/15) and code 90870 Electroconvulsive therapy (includes necessary monitoring) (work RVU= 2.50, 11/20/5). **Methodology:** 43235 (2.26) + increment of 43201-43200 (0.31)
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	2.87	2.56	3.36	3.00	1b	27	15	12	54	0.117	The Facilitation Committee agreed that the previously approved Esophagoscopy increment between the diagnostic and biopsy code (0.30 is appropriate. Therefore 0.30 was added to base code 43235 (recommended work RVU=2.26) for a recommended work RVU of 2.56), lower than the current value and below the survey 25th percentile. This value is substantiated by MPC code 36556 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older (work RVU= 2.50, 17/15/10) and code 55700 Biopsy, prostate; needle or punch, single or multiple, any approach (work RVU= 2.58, 30/15/20). **Methodology:** 43235 (2.26) + increment of 43202-43200 (0.30)
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube, or catheter	2.59	2.59	4.25	3.50	2b	33	30	15	78	0.053	The Facilitation Committee agreed that since there is no Esophagoscopy equivalent, the current value of 2.59, lower than the 25th percentile, is appropriate. This value is substantiated by code 52005 Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service (work RVU= 2.37, 29/30/20) and 57156 Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy (work RVU= 2.69, 20/30/10).

Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT	Facilitation Committee Rationale
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices	4.56	4.37	4.89	4.37	2b	41	30	20	91	0.103	The Facilitation Committee agreed that since there is no Esophagoscopy equivalent, the 25th percentile of 4.37, lower than the current value, is appropriate. This value is substantiated by code 32550 Insertion of indwelling tunneled pleural catheter with cuff (work RVU= 4.17, 40/30/20) and 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, 38/30/15).
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices	5.04	4.50	4.90	4.50	2b	41	30	20	91	0.107	The Facilitation Committee agreed that since there is no Esophagoscopy equivalent, the 25th percentile of 4.50, lower than the current value, is appropriate. This value is substantiated by code 32550 Insertion of indwelling tunneled pleural catheter with cuff (work RVU= 4.17, 40/30/20) and 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, 38/30/15).
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)	3.18	3.18	4.13	3.58	2b	33	23	15	71	0.097	The Facilitation Committee agreed that since there is no Esophagoscopy equivalent, the current value of 3.18, lower than the 25th percentile, is appropriate. This value is substantiated by code 58555 Hysteroscopy, diagnostic (separate procedure) (work RVU= 3.33, 30/25/20) and code 52332 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type) (work RVU= 2.82, 21/25/10).
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	4.32	Resurvey for April 2013	4.55	4.24	2b	41	23	15	79	0.136	The median survey intra-service time for 43246 Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube was 23 minutes, 8 minutes greater than the intra-service time for the base EGD code 43235 of 15 minutes. This led the Facilitation Committee to question the validity of the survey, in view of the previous intra-service time of 38 minutes when this code was surveyed in the 2005 Five-Year review. The expert panel was unable to explain the survey results. Therefore, the Facilitation Committee recommends resurveying code 43246 for presentation at the April 2013 RUC meeting.

Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT	Facilitation Committee Rationale
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body	3.38	3.27	4.50	3.98	2b	23	30	15	68	0.082	The Facilitation Committee agreed that the previously approved Esophagoscopy increment between the diagnostic and removal of foreign body code (1.01) is appropriate. Therefore 1.01 was added to base code 43235 (recommended work RVU=2.26) for a recommended work RVU of 3.27, lower than the current value and below the survey 25th percentile. This value is substantiated by code 36200 (work RVU= 3.02, 41/30/20) and code 50386 (work RVU= 3.30, 45/30/15). **Methodology:** 43235 (2.26)+ increment of 43215-43200 (1.01)
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire	3.15	3.01	4.10	3.64	1b	27	20	15	62	0.107	The Facilitation Committee agreed that the previously approved Esophagoscopy increment between the diagnostic and insertion of guide wire and dilator (0.75), lower than the current value and below the survey 25th percentile, is appropriate. Therefore 0.75 was added to base code 43235 (recommended work RVU=2.26) for a recommended work RVU of 3.01. This value is substantiated by code 31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa (work RVU= 2.70, 43/20/15) and code 32551 Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (work RVU= 3.29, 43/20/20. **Methodology:** 43235 (2.26) + increment of 43226-43200 (0.75)
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.90	2.77	4.07	3.36	1b	27	20	15	62	0.095	The Facilitation Committee agreed that the previously approved Esophagoscopy increment between the diagnostic and balloon dilation codes (0.51) is appropriate. Therefore 0.51 was added to base code 43235 (recommended work RVU=2.26) for a recommended work RVU of 2.77, lower than the current value and below the survey 25th percentile. This value is substantiated by code 31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa (work RVU= 2.70, 43/20/15) and 32551 Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (work RVU= 3.29, 43/20/20. **Methodology:** 43235 (2.26) + increment of 43220-43200 (0.51)
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.20	3.07	3.50	3.25	1b	24	20	14	58	0.115	The Facilitation Committee agreed that the previously approved Esophagoscopy increment between the diagnostic and removal of tumor by biopsy forceps codes (0.81) is appropriate. Therefore 0.81 was added to base code 43235 (recommended work RVU=2.26) for a recommended work RVU of 3.07, lower than the current value and below the survey 25th percentile. This value is substantiated by code 31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa (work RVU= 2.70, 43/20/15) and 32551 Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (work RVU= 3.29, 43/20/20. **Methodology:** 43235 (2.26) + increment of 43216-43200 (0.81)

Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT	Facilitation Committee Rationale
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.69	Resurvey for April 2013	4.00	3.69	2b	28	20	12	60	0.137	The median survey intra-service time for 43251 Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique was 20 minutes. Code 43235, the EGD base code which was surveyed and presented at this meeting, has 15 minutes of intra-service time, resulting in a time differential of 5 minutes between these procedures. The corresponding esophagoscopy equivalent is 43217 Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique when surveyed and presented at the October 2012 RUC meeting has 30 minutes of intra-service time while the base esophagoscopy code 43200 has 15 minutes of intra-service time resulting in a time differential of 15 minutes. This led the expert panel to question the validity of the survey and whether the median intra-service time reported by the survey participants was correct. Therefore, the Facilitation Committee recommends resurveying code 43251 for presentation at the April 2013 RUC meeting.
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	NEW	3.06	4.00	3.66	1b	27	30	20	77	0.069	The Facilitation Committee agreed that the previously approved Esophagoscopy increment between the diagnostic and optical endomicroscopy (0.80) is appropriate. Therefore 0.80 was added to base code 43235 (recommended work RVU=2.26) for a recommended work RVU of 3.06, lower than the current value and below the survey 25th percentile. This value is substantiated by code 36200 Introduction of catheter, aorta (work RVU= 3.02, 41/30/20) and code 50386 Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including rad s&i (work RVU= 3.30, 45/30/15). **Methodology:** 43235 (2.26) + increment of 431X1-43200 (0.80)
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	4.81	4.20	4.93	4.20	2b	41	30	20	91	0.097	The Facilitation Committee agreed that since there is no Esophagoscopy equivalent, the 25th percentile of 4.20, lower than the current value, is appropriate. This value is substantiated by code 32550 Insertion of indwelling tunneled pleural catheter with cuff (work RVU= 4.17, 40/30/20) and 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, 38/30/15).

Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT	Facilitation Committee Rationale
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	5.50	4.25	5.10	4.25	2b	41	45	15	101	0.068	The Facilitation Committee agreed that since there is no Esophagoscopy equivalent, the 25th percentile of 4.25, lower than the current value, is appropriate. This value is substantiated by 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, 51/45/20) and 20902 Bone graft, any donor area; major or large (work RVU= 4.58, 58/45/20).
4325X4	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	NEW	5.25	6.90	5.25	2b	38	45	20	103	0.090	The Facilitation Committee agreed that the 25th percentile work RVU of 5.25 is appropriate. To validate this value the Committee noted that since this code now contains the work of a snare (43217), band (43205) and injection (43201), the increments from these elements of work from the Esophagoscopy base diagnostic code were added together for 3.03 work RVUs. This increment was added to the base EGD code 43235 (recommended work RVU=2.26) for a work RVU of 5.29. This value is slightly less than the survey 25th percentile and is substantiated by code 20902 Bone graft, any donor area; major or large (work RVU= 4.58, 58/45/20) and code 32651 Thoracoscopy, surgical; with partial pulmonary decortication (work RVU= 5.35, 41/45/30). **Methodology:** Increment of Snare (43217/43251) [1.31]+ Banding (43205/43244) [1.41] + Injection (43201/43236) [0.31]= 3.03 added to base (43235) 2.26 = 5.29
4326X7	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	NEW	4.45	4.98	4.45	2b	38	30	20	88	0.099	The Facilitation Committee agreed that the 25th percentile work RVU of 4.45 was appropriate for this service. This value is substantiated by code 32550 Insertion of indwelling tunneled pleural catheter with cuff (work RVU= 4.17, 40/30/20) and 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, 38/30/15).
4326X8	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	NEW	4.40	5.20	4.40	2b	41	40	20	101	0.078	The Facilitation Committee agreed that the survey 25th percentile (work RVU= 4.40) is an accurate value for this procedure. This value is substantiated by 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, 44/40/20) and code 58558 Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C (work RVU= 4.74, 30/40/20).

Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT	Facilitation Committee Rationale
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)	NEW	4.39	5.75	4.39	2b	41	45	15	101	0.071	The Facilitation Committee agreed that the survey 25th percentile (work RVU= 4.39) is an accurate value for this procedure. This value is substantiated by MPC 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, 51/45/20) and code 20902 Bone graft, any donor area; major or large (work RVU= 4.58, 58/45/20).

Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT
4320X1	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	NEW	4.58	6.00	4.91	2b	41	45	18	104	0.078
4320X2	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	NEW	5.00	5.81	5.00	2b	41	45	15	101	0.089
4320X3	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	NEW	3.78	4.87	3.86	2b	41	30	16	87	0.094
4320X4	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	NEW	3.73	5.00	4.36	2b	41	30	15	86	0.091
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)	NEW	3.72	5.55	4.68	2b	40	45	15	100	0.060

Code	Description	Current RVW	Fac Comm Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT	Factiliation Committee Rationale
4320X1	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	NEW	4.58	6.00	4.91	2b	33	45	18	96	**0.078**	The Facilitation Committee agreed with the specialty society to take the equivalent EGD code 4325X4 (recommended work RVU= 5.25) and decrease the approved increment of work from the equivalent Esophagoscopy code. To substantiate this value, codes 20902 (work RVU= 4.58, 58/45/20) and 32651 (work RVU= 5.35, 41/45/30) were reviewed. **Methodology:** Corresponding 4325X4 25th percentile (5.25) - 0.67 (diff 43235-43200) = 4.58
4320X2	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	NEW	5.00	5.81	5.00	2b	33	45	15	93	0.089	The Facilitation Committee agreed with the specialty society that since there is no Esophagoscopy equivalent, the 25th percentile is an accurate value for this service. To substantiate this value, codes 20902 (work RVU= 4.58, 58/45/20) and code 32651 (work RVU= 5.35, 41/45/30) were reviewed.
4320X3	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	NEW	3.78	4.87	3.86	2b	33	30	16	79	0.094	The Facilitation Committee agreed with the specialty society that since there is no Esophagoscopy equivalent, the 25th percentile (3.86) is an accurate value for this service. To substantiate this value, codes 50386 (work RVU= 3.30, 45/30/15) and 32550 (work RVU= 4.17, 40/30/20) were reviewed. **Methodology:** Corresponding 4326X7 25th percentile (4.45) - 0.67 = 3.78
4320X4	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	NEW	3.73	5.00	4.36	2b	33	30	15	78	0.091	The Facilitation Committee agreed with the specialty society to take the equivalent EGD code 4326X8 (recommended work RVU= 4.40) and decrease the approved increment of work from the equivalent Esophagoscopy code. To substantiate this value, codes 50386 (work RVU= 3.30, 45/30/15) and 32550 (work RVU= 4.17, 40/30/20). **Methodology:** Corresponding 4326X8 25th percentile (4.40)- 0.67 (diff 43235-43200) = 3.73
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)	NEW	3.72	5.55	4.68	2b	33	45	15	93	0.060	The Facilitation Committee agreed with the specialty society to take the equivalent EGD code 4326X8 (recommended work RVU= 4.40) and decrease the approved increment of work from the equivalent Esophagoscopy code. To substantiate this value, codes 19105 (work RVU= 3.69, 45/45/15) and 11044 (work RVU= 4.10, 51/45/20) were reviewed. **Methodology:** Corresponding 4326X9 25th percentile (4.39)- 0.67 (diff 43235-43200) = 3.72

AMA/Specialty Society RVS Update Committee **Tab 10**
Facilitation Committee #1
Chemodenervation of Extremity and Trunk Muscles

Members Present: Brenda Lewis, DO (Chair), James Blankenship, MD, William Gee, MD, Charles Koopmann, MD, Larry Martinelli, MD, Geraldine McGinty, MD, Sandra Reed, MD, Joseph Schlecht, DO, George Williams, MD, Jane White, PhD, RD, FADA, LDN

646X1X
The Facilitation Committee reviewed the survey results for 646X1X and determined that the specialty recommended work RVU of 1.85 between the survey 25th and median is not appropriate for this service. The Committee determined that the survey's 25th percentile value of RVU = 1.65 is a more appropriate work value for this service. For additional support the Committee compared 646X1X to CPT code 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 pre-service, 20 intra-service, 3 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, 10 pre-service, 20 intra-service, 10 post-service).

The Facilitation Committee recommends a work RVU of 1.65 for CPT code 646X1X.

		Global	Total Time	Pre	Positioning	Intra	Post
646X1X	**Chemodenervation of one extrem; 1-4 muscles**	**000**	**40**	**10**	**5**	**20**	**5**

646X2X
The Facilitation Committee approved an adjustment to the preservice positioning time to include 5 minutes. 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 Committee reviewed the survey results for 646X2X and determined that the specialty recommended work RVU of 1.43 is not appropriate for this service; however the 25th percentile at 1.00 does not account for the intensity of additional muscles associated with performing this service. The Committee 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) is appropriate for this service, noting that 31633 has the same intraservice time as 646X2X. For additional support the Committee 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)* (RVU = 1.03, 20 minutes intra-service).

The Facilitation Committee recommends a work RVU of 1.32 for CPT code 646X2X.

		Global	Total Time	Pre	Positioning	Intra	Post
646X2X	**Chemodenervation of one extrem; each addtl extreme; 1-4 muscles**	**ZZZ**	**21**	**0**	**1**	**20**	**0**

646X3X

The Facilitation Committee reviewed the survey results 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 Committee determined that the survey's 25th percentile value of RVU = 1.82 is a more appropriate work value for this service. To supporting this value the Committee 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 pre-service, 25 intra-service, 5 post-service) and CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU = 1.56, 15 pre-service, 25 intra-service, 10 post-service).

The Facilitation Committee recommends a work RVU of 1.82 for CPT code 646X3X.

		Global	Total Time	Pre	Positioning	Intra	Post
646X3X	**Chemodenervation of one extrem; 5 or more muscles**	**000**	**45**	**10**	**5**	**25**	**5**

646X4X

The Facilitation Committee approved an adjustment to the preservice positioning time to include 5 minutes. 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 Committee also approved an adjustment to the intraservice time to add 5 minutes to be consistent with the base code reported with the add-on code. The Committee reviewed the survey results for 646X4X and determined that the specialty recommended work RVU of 1.70 is not appropriate for this service; however the 25th percentile at 1.20 does not account for the time needed to perform this service. The Committee 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 of additional muscles. The RVU was determined by starting with the proposed 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 Facilitation Committee compared 646X4X 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 pre-service, 25 intra-service, 5 post-service) and CPT code 60100 Biopsy thyroid, percutaneous core needle (work RVU = 1.56, 15 pre-service, 25 intra-service, 10 post-service).

The Facilitation Committee recommends a work RVU of 1.52 for CPT code 646X4X.

		Global	Total Time	Pre	Positioning	Intra	Post
646X4X	**Chemodenervation of one extrem; each addtl extreme; 5 or more muscles**	**ZZZ**	**26**	**0**	**1**	**25**	**0**

646X5X

The Facilitation Committee reviewed the survey results for 646X5X and determined that the specialty recommended work RVU of 1.80, survey 25th percentile is appropriate for this service. The Committee compared 646X5X to CPT code 56820 *Colposcopy of the vulva;* (work RVU = 2.05, 15 pre-service time, 15 intra-service time, 10 post-service time) 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).

The Facilitation Committee recommends a work RVU of 1.80 for CPT code 646X5X.

		Global	Total Time	Pre	Positioning	Intra	Post
646X5X	**Chemodenervation of trunk; 1-5 muscles**	**000**	**40**	**10**	**5**	**20**	**5**

646X6X

The Facilitation Committee reviewed the survey results for 646X6X and determined that the specialty recommended work RVU of 2.11, survey 25th percentile is appropriate for this service. The Committee 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 pre-service, 25 intra-service, 5 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 pre-service, 25 intra-service, 10 post-service).

The Facilitation Committee recommends a work RVU of 2.11 for CPT code 646X6X.

		Global	Total Time	Pre	Positioning	Intra	Post
646X6X	**Chemodenervation of trunk; 6 or more muscles**		**45**	**10**	**5**	**25**	**5**

AMA/Specialty Society RVS Update Committee **Tab 11**
Facilitation Committee #1
Chemodenervation of Neck Muscles

Members Present: Brenda Lewis, DO (Chair), James Blankenship, MD, William Gee, MD, Charles Koopmann, MD, Larry Martinelli, MD, Geraldine McGinty, MD, Sandra Reed, MD, Joseph Schlecht, DO, George Williams, MD, Jane White, PhD, RD, FADA, LDN

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

The Facilitation Committee approved an adjustment to the pre-service package to 5 (Procedure without sedation/anesthesia care), with the addition of 3 minutes of preservice time for mixing the toxin. This results in physicians work times of 15 pre-service, 15 intra-service and 5 post-service. The Facilitation Committee reviewed the survey results for 64613X 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)* (RVU=1.85, 15, 15, 5) because 64615 has the same time, is part of the same 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 Committee determined that the survey's 25th percentile value of RVU = 1.79 is a more appropriate work value for this service. The Committee compared 64613X to CPT code 53855 *Insertion of a temporary prostatic urethral stent, including urethral measurement* (work RVU = 1.64, 15 minutes intra) and 64425 *Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves* (work RVU = 1.75, 15 minutes intra) which requires the same intraservice physician work to perform.

The Facilitation Committee recommends a work RVU of 1.79 for CPT code 64613X.

6461XX

The Facilitation Committee approved an adjustment to the intra-service time because the complications involved in injecting the airway begins in the intra-service time. 5 minutes scrub dress and wait was removed and 5 minutes added to the intra-service time. The Facilitation Committee approved the 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 time. The physician work times are 16 pre-service, 15 intra-service and 5 post-service for a total time of 36. The Committee reviewed the survey results for 6461XX and determined that the specialty recommended work RVU of 2.19 is not appropriate for this service. The Committee determined that based on the survey, the median is overvalued at a work value of 2.30, but the 25th percentile is undervalued at a work value of 1.82 based on the level of complexity and risk associated with the code. The Committee determined that 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. 6461XX has slightly less total time, but the same intraservice time and it is a more intense code to perform. For additional support the Facilitation Committee compared 6461XX to MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina;* (work RVU = 1.50, 15 pre-service, 15 intra-service, 10 post-service), with the same intra-service and less intense to perform and MPC code *52000 Cystourethroscopy (separate*

procedure) (work RVU=2.23, 17pre-service, 15 intra-service,10 post-service), with the same intrs-service and more intense to perform.

The Facilitation Committee recommends a work RVU of 2.06 for CPT code 6461XX.

AMA/Specialty Society RVS Update Committee
Facilitation Committee #1
CT Angiography

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Members Present: Brenda Lewis, DO (Chair), James Blankenship, MD, William Gee, MD, Charles Koopmann, MD, Alan Lazaroff, MD, Larry Martinelli, MD, Sandra Reed, MD, Joseph Schlecht, DO, George Williams, MD, Jane White, PhD, RD, FADA, LDN

The Facilitation Committee discussed the physician work and time associated with CPT Codes 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* and 72191 *Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed*, and their appropriate work RVU relative to similar services, after the work RVU presented as a family by the specialty societies was rejected by the RUC. The following is a summary of the facilitation committee's recommendation:

	72191	74174	74175
Pre-Evaluation		5	
Intra-Service		30	
Post-Time		5	
Total Time		40	
RVU		2.20 (Approved)	

72191 ***Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed***

The RUC initially reviewed this code and determined that a work RVU of 1.81 overstated physician work.

The RUC compared 100XX1 to 10180 *Incision and drainage, complex, postoperative wound infection* (work RVU=2.30) and initially agreed that physician work and times were similar. However, after further review, the committee members came to a consensus that CPT code 10180 should not be used since time is based on Harvard, there is no imaging and there is variation in global periods. The committee also pointed out that this code may be misvalued and should be referred to RAW for further review. The committee also reviewed physician time and determined that pre-service package 1b- Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care) was more appropriate compared to 2b- Difficult Patient/Straightforward Procedure (With sedation/anesthesia). The committee agreed that an additional 2 minutes for pre-service evaluation and 4 minutes for pre-service positioning to account for skin preparation and positioning used for ultrasound is appropriate. In addition, the committee agreed with the specialty society's recommendation of 20 minutes for post-service time. Physicians spend time educating nursing staff, family members and the patient on maintaining and caring for the

catheter, in addition to typical post service work activities, such as reviewing and interpreting images, completing orders and reports and assessing vital signs.

The committee determined that a work RVU of 3.00, the survey 25th percentile appropriately accounts for the physician work. 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 100X1 was greater. For additional support, the committee reviewed CPT codes 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU=3.12), 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 these services were similar in physician work and intensity. **The facilitation committee recommends a work RVU of 3.00, the survey 25th percentile for CPT code 100XX1 and the following times:**

74174 ***Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing***

The facilitation committee reviewed the survey results for CPT code 4900X2 and determined that a work RVU of 4.25, the survey 25th percentile appropriately accounts for the physician work and time. The committee noted that this service was previously reported using a combination of 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 agreed that pre-service package 2b- Difficult Patient/Straightforward Procedure (With sedation/anesthesia) with adjustments of 2 minutes for pre-service evaluation and 4 minutes for pre-service positioning are appropriate for imaging. 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 facilitation committee recommends a work RVU of 4.25, the survey 25th percentile for CPT code 4900X2.**

AMA/Specialty Society RVS Update Committee **Tab 14**
Facilitation Committee #2
Respiratory Motion Management Simulation

Members Present: Walt Larimore, MD (Chair), Ron Burd, MD, Scott Collins, MD, John Gage, MD, Anthony Hamm, DC, David C. Han, MD, Stephen Lahey, MD, Timothy Laing, MD, Marc Leib, MD, J. Leonard Lichtenfeld, MD, Daniel J. Nagle, MD, J. Allan Tucker, MD

77295 Therapeutic radiology simulation-aided field setting; 3-dimensional
The Committee reviewed the survey results for 77295 and determined that the specialty recommended current work RVU of 4.56 was not appropriate for this service. The Committee 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, 115 minutes intra, 0 minutes post), 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 Committee determined that 77338 is an appropriate crosswalk and determined that a work RVU of 4.29 is appropriate for 77295.

For additional support, the Committee compared 77295 to similar services 77787 *Remote after loading high dose rate radionuclide brachytherapy; over 12 channels* (work RVU = 4.89, 20 minutes pre, 90 minutes intra, 20 minutes post) 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).

Additionally the Committee reviewed and compared the intensity of similar services 77301 *Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications* and 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)* and determined that the recommended work RVU of 4.29 appropriately ranks this service when comparing the intensity.

The Facilitation Committee recommends a work RVU of 4.29 for CPT code 77295.

AMA/Specialty Society RVS Update Committee **Tab 16**
Facilitation Committee #2
Percutaneous Closure PDA

Members: Doctors Walt Larimore (Chair), Ron Burd, Scott Collins, John Gage, Anthony Hamm, DC David C. Han, Stephen Lahey, Timothy Laing, Marc Leib, J. Leonard Lichtenfeld, Daniel J. Nagle, and J. Allan Tucker.

9358X2 ***Percutaneous transcatheter closure of patent ductus arteriosus***
The Committee reviewed the survey results for 9358X2 and after a robust discussion determined the survey 25th percentile work RVU of 14.00 appropriately accounts for the physician work required to perform this service. The Committee 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 Committee reviewed the intra-service description for 9358X2 and determined that although the surveyed service requires 10 minutes less of intra-service time it is more intense. The Committee noted that 92941 is typically performed on an adult, whereas 9358X2 is performed on an infant.

The Committee also 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) to gauge what the differential between performing the same service on a child versus an adult. The differential is 55% between these two services. The Committee reviewed 59076 *Fetal shunt placement, including ultrasound guidance* (work RVU = 8.99) and multiplied it times the child/adult differential (8.99 x 1.55 = 13.95), which results in a work RVU approximately the same as the survey 25th percentile work RVU. **The Committee recommends the survey 25th percentile work RVU of 14.00 for CPT code 9358X2.**

AMA/Specialty Society RVS Update Committee
Facilitation Committee #2
Arthroplasty

Members Present: Walt Larimore, MD (Chair), Ron Burd, MD, Scott Collins, MD, John Gage, MD, Anthony Hamm, MD, David C. Han, MD, Stephen Lahey, MD, Timothy Laing, MD, Marc Leib, MD, J. Leonard Lichtenfeld, MD, Daniel J. Nagle, MD, J. Allan Tucker, MD

The Facilitation Committee discussed the physician work and time associated with CPT Codes 27447 *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)* and 27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft* and their appropriate work RVU relative to similar services, after the work RVU of 22.13 presented by the specialty societies for 27447 was rejected by the RUC. The following is a summary of the facilitation committee's recommendation:

	27130 (crosswalked to 63075)-45400 & 44188	**27446 (Approved by the RUC)**	**27447 (crosswalked to 63075)-45400 & 44188**
Pre-Eval	40 minutes	40 minutes	40 minutes
Pre-Positioning	15 minutes	15 minutes	15 minutes
Scrub, Dress & Wait	20 minutes	20 minutes	20 minutes
Intra-Service	100 minutes	90 minutes	100 minutes
Post-Time	25 minutes	20 minutes	25 minutes
Hospital Visits	(2) 99231 (1) 99232	(1) 99231 (1) 99232	(2) 99231 (1) 99232
Discharge	(1) 99238	(1) 99238	(1) 99238
Office Visits	(1) 99212 (2) 99213	(1) 99212 (2) 99213	(1) 99212 (2) 99213
RVU	**19.60**	**17.48**	**19.60**

AMA/Specialty Society RVS Update Committee **Tab 21**
Facilitation Committee #2
Thromboendarterectomy

Members: Doctors Walt Larimore (Chair), Ron Burd, Scott Collins, John Gage, Anthony Hamm, DC David C. Han, Stephen Lahey, Timothy Laing, Marc Leib, J. Leonard Lichtenfeld, Daniel J. Nagle, and J. Allan Tucker.

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

The Committee reviewed the survey results for CPT code 35301 and determined that the survey 25th percentile work RVU of 23.00 was too high. The Committee agreed with the surveyed physician times of 75 minutes pre, 120 minutes intra and 30 minutes immediate post-service time. The Committee compared the surveyed service to 35231 *Repair blood vessel with vein graft; neck* (work RVU = 21.16 and 60 minutes pre, 120 minutes intra and 30 minutes immediate post-service time) and determined that 35301 require the same physician work and nearly the same physician time to perform. Therefore, the Committee recommends crosswalking 35301 to code 35231 for a work RVU of 21.16.

The Committee also identified many similar services performed by this specialty and across the physician payment schedule to support the relativity of this service. The Committee determined that a work RVU of 21.16 for 35301 is appropriate compared to codes 35621 *Bypass graft, with other than vein; axillary-femoral* (work RVU = 21.03 and 120 minutes intra-service time), 35661 *Bypass graft, with other than vein; femoral-femoral* (work RVU = 20.35 and 120 minutes intra-service time and 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 120 minutes intra-service time).

Lastly, the Committee also determined that the survey 25th percentile work RVU of 23.00 replacing the 99291 critical care visit with the 99233 subsequent hospital care visit (4.50-2.00 = 2.50) results in a work RVU of 20.50, which supports the recommended crosswalk. **The Committee recommends a work RVU of 21.16 for CPT code 35301.**

The Committee reviewed the direct practice expense and accepts the standard inputs as presented and accepted by the PE Subcommittee.

Development of a Model for the Valuation of Work Relative Value Units (RVUs)

The Centers for Medicare and Medicaid Services (CMS) has contracted with the Urban Institute (UI) and its subcontractors Social & Scientific Systems, Inc. (SSS) and RTI International to examine the work relative value units (RVUs) for 100 services and develop a validation process for the RVUs used in the Medicare Physician Fee Schedule for both new and existing services. The project aims to provide CMS with a process for reviewing proposed work RVUs, assessing how reasonable they are relative to external data and assuring that the relativities within the overall RBRVS fee schedule are internally consistent within families of services and specialties as well as across families. Work RVUs reflect both the time it takes to provide a physician service and the intensity of the service (i.e., technical skill, physical effort, mental effort and judgment, and stress due to patient risk). Given the central role of time in establishing work RVUs and the concerns that have been raised about the current time values, a key focus of the project is developing alternative time estimates for study services. The work validation process incorporates these time estimates in clinical panel process through which clinicians from a range of specialties will help review the implications of the time estimates for current work values. There are three key aspects to the project.

Alternative Estimates of Service-level Time. Development of alternative time estimates will use a variety of approaches, depending on the type of service. First, time estimates will be developed from health systems' operating room logs, electronic health records, scheduling records, billing information, chart review, as well as direct observation of physician-patient interactions. This will be a very resource-intensive part of the project, but is essential to addressing the various concerns that have been raised about current time values and resulting work values. In addition, secondary sources that may support calculation of service-level times, such as National Surgical Quality Improvement Program (NSQIP), will be examined and used, if feasible.

Data Analysis. These alternative time estimates will be compared to the current time values used in the fee schedule. These comparisons will examine the relationship between the alternative measures and current values by type of service, place of service, and other exogenous characteristics. The project team will develop alternative models of the relationship between work and time that will be presented to the clinical panels for their consideration.

Clinical Panels. The project team will convene groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time. The groups will discuss both the time data and their implications for work values and the family of services for which work values could be adjusted based on the studied services. For example, if they conclude that the work-to-time ratio was appropriate for a given studied service so that lower time estimates suggest that work should be lower, they will identify any similar services whose work values could be adjusted. The goal is to translate the new time estimates into new work values, as feasible, and expanding the services refined beyond those specifically included in the time measurement part of the study.

The project team includes national health policy experts whose research has helped shape Medicare physician payment policies for over two decades. Stephen Zuckerman, Ph.D., will serve as the Principal Investigator for this proposed project and Katie Merrell of SSS will be the Co-PI. Robert Berenson, M.D., will serve as Clinical Director for the project, providing clinical and policy expertise as well as recruiting and training the physicians who will lead the clinical panels – a critical element of the proposed project. He will work on these activities with project consultant Peter Braun, M.D., who was the Co-PI for the original Harvard RVU study. Nancy McCall of RTI will direct the collection of new time data that will be used as part of the validation model to be developed in this study.