

**AMA/Specialty RVS Update Committee  
Meeting Minutes  
October 4-6, 2012**

**I. Welcome and Call to Order**

Doctor Barbara Levy called the meeting to order on Friday, October 5, 2012, at 8:00 am.  
The following RUC Members were in attendance:

|                              |                                    |
|------------------------------|------------------------------------|
| Barbara Levy, MD             | Allan A. Anderson, MD*             |
| Michael D. Bishop, MD        | Margie C. Andreae, MD*             |
| James Blankenship, MD        | Gregory L. Barkley, MD*            |
| Dale Blasier, MD             | Gregory DeMeo, MD*                 |
| Albert Bothe, MD             | Jane Dillon, MD*                   |
| Joel Bradley, Jr., MD        | Verdi DiSesa, MD*                  |
| Scott Collins, MD            | William D. Donovan, MD, MPH, FACR* |
| John O. Gage, MD             | Jeffrey Paul Edelstein, MD*        |
| William F. Gee, MD           | Yul Ejnes, MD*                     |
| Anthony Hamm, DC             | William E. Fox, MD, FACP*          |
| David C. Han, MD             | Daniel McQuillen, MD*              |
| David F. Hitzeman, DO        | Terry L. Mills, MD*                |
| Charles F. Koopmann, Jr., MD | Eileen Moynihan, MD*               |
| Timothy Laing, MD            | Daniel Nagle, MD*                  |
| Walt Larimore, MD            | Margaret Neal, MD*                 |
| Alan Lazaroff, MD            | Scott D. Oates, MD*                |
| M. Douglas Leahy, MD, MACP   | Chad A. Rubin, MD, FACS*           |
| Brenda Lewis, DO             | M. Eugene Sherman, MD*             |
| Scott Manaker, MD, PhD       | Daniel Mark Siegel, MD*            |
| William J. Mangold, Jr., MD  | Norman Smith, MD*                  |
| Lawrence Martinelli, MD      | Holly Stanley, MD*                 |
| Geraldine B. McGinty, MD     | Stanley W. Stead, MD, MBA*         |
| Gregory Przybylski, MD       | Robert J. Stomel, DO*              |
| Marc Raphaelson, MD          | G. Edward Vates, MD*               |
| Sandra B. Reed, MD           | Jane White, PhD, RD, FADA, LDN*    |
| Peter Smith, MD              | Jennifer L. Wiler, MD*             |
| J. Allan Tucker, MD          | Fredrica E. Smith, MD*             |
| James C. Waldorf, MD         |                                    |
| George Williams, 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

- Doctor Levy welcomed the Chair-elect of the American Medical Association Board of Trustees, David O. Barbe, MD, MHA, who speaking on behalf of the AMA thanked the RUC for its work and offered the continued support of the AMA.
- Doctor Levy welcomed the following observers:
  - John K. Iglehart, Founding Editor of Health Affairs and contributor to The New England Journal of Medicine.
- Doctor Levy welcomed the following new RUC members:
  - Geraldine McGinty, MD - American College of Radiology
  - William Donovan, American College of Radiology Alternate
  - Bill Mangold, AMA Representative
  - Eileen Moynihan, AMA Representative Alternate
  - Lawrence Martinelli, Infectious Diseases Society
  - Daniel McQuillen, MD, Infectious Diseases Society of America Alternate
  - M. Douglas Leahy, MD, MACP, Primary Care Rotating Seat
  - Yul Ejnes, MD Primary Care Rotating Seat Alternate
  - William Fox, American College of Physicians Alternate
  - Dan Nagle, American Academy of Orthopedic Surgeons Alternate
  - Scott Manaker, Practice Expense Subcommittee, Chair
  - Fredrica E. Smith, College of Rheumatology Alternate
- Doctor Lichtenfeld is not at the meeting and is recovering from surgery. The RUC wishes him well.
  - In Doctor Lichtenfeld's absence the RUC will allow alternates for both of the ACP's seats at the table.
- Between meetings Doctor Levy and Doctor Hollman meet with CMS:
  - They spoke with Jonathan Blum regarding the Transition Care Management (TCM) and the Care Coordination Codes (CCC). CMS understands that they will receive the RUC recommendations for these new codes, immediately following the meeting. They talked about the difference between the G-codes outlined in the proposed rule and the TCM and CCC codes as proposed by CPT. CMS was receptive to the coding proposals that we have in place. CMS was also appreciative of the work that the CPT and the RUC has done with the Care Coordination Workgroup (C3W) to develop coding that captures the work and value of care coordination, and promotes care coordination to reduce readmissions. Mr. Blum, having been at the April meeting, was impressed with the work of the RUC and the C3W.
- A reminder that there is a confidentiality policy that needs to be signed at the registration table.
- 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.
- A reminder that the Administrative Subcommittee decided at the January 2012 RUC meeting to publish the RUC vote count beginning with the October 2012 meeting, following publication of the November 2013 Final Rule for the 2014 Medicare Physician Payment Schedule.
- The database from 2012 contains the old MPC list. The validated new MPC list is on the table.

- We have obtained Medicaid utilization data to be added to the RUC database. This will be very useful for those codes that the RUC reviews that do not have utilization under Medicare.

### **III. Director's Report**

- As we are often dealing with media inquiries and responses, we want to take a more proactive approach.
- AMA Communications team has put together a new strategy for CPT and the RUC:
  - A more ready use of press releases for achievements, i.e. a press release was sent to the media regarding the early release of CPT 2013 and some of the major coding changes within that release.
  - We are hopeful that CMS will rely on CPT and favorably review the RUC recommendation for the TCM codes in the Federal Register Nov. 1<sup>st</sup>. We will make sure that the public knows that CPT and the RUC contributed to that effort.
  - As part of this effort we will also include a short video clip on the CPT and RUC websites, explaining what the committees do. A film crew will be around today, taking video of the room for a visual backdrop. In addition, they will be doing brief interviews with RUC and HCPAC members and advisors. I encourage you to talk to them.

### **IV. Approval of Minutes of the April 26-28, 2012 RUC Meeting**

**The RUC approved the April 2012 RUC Meeting Minutes as submitted.**

### **V. CPT Editorial Panel Update (Informational)**

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

- The CPT 2013 book was available by file by the end of August 2012. The CPT 2013 book was sent to members and customers by mid-September 2012. It is the second year in a row that it has been released early, providing providers and payers with a longer lead time to get their systems ready for the January changes to codes and values.
- The Chronic Care Coordination Workgroup (C3W) has been meeting since last February. CPT was able to complete its portion of the work and get the coding language into the 2013 CPT book and to the RUC in time for the codes to be valued at this meeting.
- The next CPT meeting starts Oct 11, 2012 in Memphis, TN. Among other topics at the annual meeting items of interest include:
  - Quantitative Drug Testing
  - Presentation from the Molecular Pathology Workgroup
  - Performance Measure Coding, i.e. role of CPT in turning performance measures into CPT codes, especially in the midst of a shift to large group and registry electronic reporting, rather than individual paper reporting by practitioners.
  - RAW issues from the last RUC meeting
    - Bundling of breast biopsy services with imaging
    - Imaging use in abscess drainage
    - Clarification on the radical soft tissue tumors
    - Completing the distinctions between category 1 and category 3 and the rules of interaction between those levels.
    - New lobbying policy finalized

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

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

- Working to complete the Final Rule. Thank you to those societies that have come to the agency to discuss issues.
- Final Rule will come out around November 1<sup>st</sup>.
- Congress is in recess, so there is nothing to say currently about legislative issues.

## **VII. Washington Update (Informational)**

Sandy Marks, AMA Assistant Director of Federal Affairs, provided the RUC with the following information regarding the AMA's advocacy efforts:

- AMA Comments on 2013 Medicare Physician Payment Schedule Proposed Rule
  - AMA comments agree with and underscore RUC comments on care coordination codes, multiple procedure policy and other issues
  - Last spring, AMA wrote CMS to express concerns about convergence of 2015 penalties for PQRS, value-based modifier (VBM), eRx, and Meaningful Use EHR incentive programs
  - Especially concerned about plan to “back date” programs by setting 2013 as “performance year” for 2015 incentives and penalties
  - Also concerned because of lengthy delays in experience reports for eRx & PQRS programs and lack of timely physician feedback to date
  - Responses to AMA Concerns
    - 2013 proposed rule offers some policies that seem designed in part to address AMA concerns
    - CMS is maintaining its policy that 2013 will be “performance year” for 2015 penalties, but proposals will help physicians avoid these penalties
    - Application of the VBM will be aligned with participation in PQRS program
    - Physicians who successfully participate in PQRS will be exempt from application of VBM unless they volunteer to be in VBM pool
    - New reporting options allow individual physicians who successfully report on one PQRS measure or measures group to avoid PQRS penalty
    - Initially, VBM only applies to groups of 25 or more physicians and other eligible professionals
    - Physicians who seek administrative claims review option can avoid both PQRS and VBM penalties
    - Physicians who attest for Meaningful Use EHR program would be exempt from eRx penalties
    - eRx informal review/appeals process proposed
  - AMA Comments on 2013 Proposals can be found at [www.ama-assn.org/go/regrelief](http://www.ama-assn.org/go/regrelief)
  - In the comments the AMA addressed the following PQRS issues:
    - Support new reporting options, i.e., administrative claims, reporting one measure or measure group
    - 12 clinical quality measures (CQM) are too many to require for physicians to meet CQM component of EHR

- many measures are for primary and preventive care so difficult for some specialties to report on 12
- Recommend each report 9 CQMs covering 3 domains
- Allow PQRS credit for other meaningful quality improvement activities, such as regional programs
- Physicians in groups that report through GPRO should still be able to report individual measures, such as through a registry for their specialty
- Measure development should be done by multi-stakeholder organizations, especially those including physicians, since they are end users of measures
- Registry measures reported in last 6 months of year should get full 12-month incentive payment
- Many comments on specific PQRS measures
- In the comments the AMA addressed the following Value-Based Modifier issues:
  - Continue to oppose back-dating of VBM to 2013
  - Instead of applying VBM to groups of 25 or more physicians and other professionals, apply to groups of 100 or more physicians
  - Physicians in VBM groups should be able to avoid penalties through individual participation, not just group
- In the comments the AMA addressed the following E-Prescribing issues:
  - Support proposal to upgrade eRx standards for Part D, but urge CMS to finalize standards for prior authorization
  - Protect physicians from penalties due to vendor non-compliance with upgrade standards
  - Support proposal to reduce GPRO threshold to 2-24 physicians, recommend threshold for these GPROs of 75 eRx reports
  - Previous exemptions for rural with limited internet; few pharmacies with eRx; law & regulation; <100 Rx
  - Support proposed new exemptions for Meaningful Use EHR and adoption of certified EHR technology
  - New exemptions should be available to any physician who attests or registers for Meaningful Use in 2011-13
  - Recommend exempting physicians nearing retirement
  - Support proposal for informal review/appeals process, but should also be available for 2012 program
- In the comments the AMA addressed the following Quality and Resource Use Reports (QRUR) issues:
  - Provided a number of QRUR comments to CMS and also attached these comments to our comment letter
  - Comments focus on reports' format, methods, analyses and needed outreach to physicians
  - Example: need for patient-level detail, drill-down format, reconsideration mechanism, attribution issues
  - We helped substantially increase number of physicians who reviewed QRUR; CMS taking comments seriously
  - Will provide QRURs based on 2011 data to 30,000 physicians in IA, KS, MO, NE, CA, IL, MI, MN, WI
  - Significant changes not expected in next set of reports
  - CMS to redo template for 2013 QRURs using 2012 data
  - Appreciate input from RUC participants who reviewed reports and provided feedback

- CMS did not make proposals in this proposed rule on GPCIs because the next update is in 2014, but CMS did analyze IOM recommendations
  - AMA urged CMS to consider and avoid significant disruption due to breaking apart statewide localities
  - MedPAC expected to recommend retaining ¼ work GPCI but letting floor expire, and ask Congress to direct HHS to develop new work GPCI tied to “market fees”
  - MedPAC is also reviewing equalizing payments across ambulatory settings
    - For services that meet criteria, may recommend reducing facility payment so total pay to outpatient department would be equal to physician office rates
- MEI Technical Advisory Panel
  - In June, CMS Actuary convened expert panel to seek review and refinement of the MEI
  - First truly comprehensive review since its creation
  - Panel included AMA economist Kurt Gillis, PhD, and several other leading national experts
  - In 3 TAP meetings, open to public, a number of potential refinements to the MEI were identified:
    - Change physician compensation price proxy to professional and technical worker wages instead of all private non-farm workers
    - New category for clinical labor (health care workers)
    - “Other professional services” category to account for billing & legal service costs
    - Refine certain office expenses to reflect IT costs
    - Use professional office building rents instead of residential rents
    - Explore methods of gathering data to update MEI weights, including potential future AMA-CMS survey
    - AMA believes MEI changes will better reflect input costs and prices medical practices actually face
    - Urged CMS to adopt on interim basis for 2013
- Observation Care Comment Letter
  - AMA commented on Hospital Outpatient PPS rule
  - Seeking greater clarity on patient hospital status
  - Called for CMS to establish Task Force to review 3-day stay policy, hold stakeholder workshops
  - Prohibit black box edits
  - Prohibit RAC review of admission medical necessity
  - Require admitting physician’s approval before making any changes in patient status
- SGR Outlook and Transition
  - Most recent forecast is 27% cut in 2013
  - 2011 failure to agree on deficit reduction means 2013 sequester, on top of 27%
  - CBO score for SGR repeal now \$245 B over 10 years
  - Other factors Congress must address: expiring tax cuts, debt ceiling, health & defense sequester cuts
  - No one can really predict lame duck outcome:
  - AMA advocating for permanent SGR solution

- Previously organized medicine reached consensus on 3 steps: repeal formula, 5 years of statutory updates, then new system building on new payment and delivery models
- SGR Status Quo Is Unacceptable
  - Updates from 2001-12 average 0.3% per year
  - Medicare policy is inflexible, i.e., physicians who improve care and reduce patients' need for acute care services can lose revenue
  - New payment models can offer physicians opportunities to lead changes in care delivery and share in savings
  - To secure congressional action on \$245 B SGR repeal, profession must demonstrate progress with payment and delivery reforms
- Developing Roadmap for Future Delivery System Is an Opportunity for Leadership
  - Widespread support exists for eliminating SGR and starting national movement to payment & delivery models that improve quality and care coordination while lowering cost growth
  - Despite these shared goals, no one has a viable plan to get from here to there
  - This gap presents a major opportunity for medical profession to demonstrate leadership and shape its own future
- Need to Define Core Elements for Transition to New Medicare Payment Policy
  - SGR Task Force of 7 specialty and 8 state societies asked AMA to develop a set of driving principles and core elements for a transition to new payment models that they all can support, allowing profession to present unified message
- Transitioning from the SGR to a Higher Performing Medicare Program
  - Driving principles at foundation of transition plan:
    - Successful delivery reform is essential foundation for transitioning to high performing Medicare program that meets health care needs of diverse patient population
    - Medicare must invest and support physician infrastructure that provides platform for delivery and payment reform
    - Medicare payment updates should reflect efforts and progress on quality improvements and managing costs
  - Core elements that must be included:
    - Reflect practice diversity, provide opportunities for physicians to choose payment models that work for their patients, practice, specialty and region
    - Encourage incremental changes with positive incentives and rewards during defined timetable, instead of using penalties to order abrupt changes in care delivery
    - Provide a way to measure progress and show policymakers that physicians are taking accountability for quality and costs
  - Plan needs to be structured in a way that will:
    - Reward physicians for savings achieved across the health care spectrum
    - Enhance prospects for physicians adopting new models to achieve positive updates
    - Tie incentives to physicians' own actions, not actions of others or factors beyond their influence

- Enhance prospects to harmonize measures and alter incentives in current law
- Encourage systems of care, regional collaborative efforts, primary care and specialist cooperation while preserving patient choice
- Allow specialty and state society initiatives to be credited as delivery improvements (deeming authority) and recognize central role of the profession in determining and measuring quality
- Provide exemptions and alternative pathways for physicians in practice situations in which making or recovering investments that may be needed to reform care delivery would constitute hardship

#### **VIII. Relative Value Recommendations for CPT 2013:**

##### **Chest Tube Interventions (Tab 4)**

**Alan Plummer, MD, (ATS), Burt Lesnick MD (ACCP); Kathrin Nicolacakis, MD, (ATS) and Robert DeMarco, MD (ACCP)**  
*Facilitation Committee #2*

In September 2011, CPT Codes 32420 *Pneumocentesis, puncture of lung for aspiration*, 32421 *Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent* and 32422 *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)* were identified in the Harvard Valued-Utilization over 30,000 screen. At that time, the specialty societies requested, and the RUC agreed that these services should be referred to the CPT Editorial Panel to correctly describe current practice. In February 2012, the CPT Editorial Panel created 32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance*, 32555 *Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance*, 32556 *Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance* and 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* and deleted 32420-32422 to accurately describe these procedures.

The family of codes was initially reviewed by the RUC at the April 2012 meeting. The RUC noted that the specialty societies used a split survey process. Specifically, CPT codes 32554 and 32556 were surveyed primarily by pulmonologists and CPT codes 32555 and 32557 were surveyed by radiologists. The split survey process made it difficult to ascertain the appropriate increment of physician work within this family of services. The RUC recommended that the entire family of codes be resurveyed for the October 2012 RUC meeting. The RUC recommended that pulmonary medicine resurvey all four codes and radiology resurvey only the imaging codes (32555 & 32557). It was noted at the October 2012 meeting that the RUC recommended interim valuation in April 2012 based on incorrect utilization assumptions.

***32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance***



The RUC initially reviewed this code and determined that this service was previously reported as 32421 *Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent* (work RVU=1.54) based on the CPT code description. However, after a robust discussion with the specialty societies, the RUC agreed that this service was actually reported using a blend of 32421 and 32422 *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)* (work RVU=2.19). Coding documents published over the past decade were discussed which supported this coding convention. The new service described by CPT code 32554 includes thoracentesis, needle **or** catheter, and therefore should be valued using both 32421 and 32422. In addition, the specialty societies confirmed that the typical service is with catheter as opposed to needle, which further supports that this service is a blend of the two previously reported services (32421 & 32422). The RUC crosswalked this service to CPT code 36569 *Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older* (work RVU=1.82) because they both require the same physician

work RVU of 1.82 which is less than the 25<sup>th</sup> percentile appropriately accounts for the physician work. Furthermore, the RUC reviewed CPT codes 45315 *Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique* (work RVU=1.80), 57456 *Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage* (work RVU=1.85) and 64416 *Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)* (work RVU=1.81) and agreed that these services were similar in physician work and intensity. The RUC also agreed that an additional 2 minutes for positioning is appropriate. **The RUC recommends a work RVU of 1.82, less than the 25<sup>th</sup> percentile for CPT code 32554.**

**32555 *Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging***

The RUC reviewed the survey results from 90 physicians for CPT code 32555. The RUC determined that a work increment to account for imaging in relation to CPT code 32554 was appropriate. It was reported by the specialty societies and confirmed by the RUC that CPT codes 32421 and 32422 were previously reported with 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU=.67, intra time=30 minutes). However, the overall survey median intra service time was 20 minutes and therefore the RUC agreed that an increment of 0.45 work RVUs appropriately account for the imaging increment over code 32554. This service was compared to 57400 *Dilation of vagina under anesthesia (other than local)* (work RVU=2.27). The RUC also agreed that an adjustment of 2 minutes for pre-service evaluation and positioning appropriately account for the additional time prior to skin prep necessary for ultrasound localization of a suitable pocket of fluid. **The RUC recommends a work RVU of 2.27 for CPT code 32555 which is between the 25<sup>th</sup> percentile and median survey value.**

**32556 *Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance***

The RUC reviewed the survey results for CPT code 32556 and noted that this new service was previously reported as 32551 *Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)* (work RVU=3.29). However, the members determined that a work RVU of 2.50 based on the

survey 25<sup>th</sup> percentile is more appropriate. To support this value, the RUC reviewed CPT codes 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU=2.33), 90870 *Electroconvulsive therapy (includes necessary monitoring)* (work RVU=2.50) and 36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* (work RVU=2.68). The RUC also agreed that an additional 2 minutes for positioning is appropriate. The RUC determined that the incremental increase across this family accurately captures the intensity and physician work. **The RUC recommends a work RVU of 2.50 for CPT code 32556.**

***32557 Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance***

The RUC reviewed the survey results from 74 diagnostic radiologists, interventional radiologists and pulmonologists. The RUC determined that a work increment in relation to CPT code 32556 to capture imaging is appropriate. The specialty societies noted and the RUC agreed that this service was previously reported with 32551 and 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 RUC determined that the survey median of 3.62 was appropriate to account for the physician work required to perform this service. The RUC noted and agreed that this service has evolved and is more complex. In the past, the procedure was based on anatomic landmarks, however, current practice suggests that imaging guidance is used prior to catheter placement to avoid injury to the lung and pleura, as well as periodic imaging to ensure optimal drainage of the pleural effusion. The RUC also agreed that an adjustment of 2 minutes for pre-service evaluation and positioning appropriately account for the additional time prior to skin prep necessary for ultrasound localization of a suitable pocket of fluid. **The RUC recommends a work RVU of 3.62 for CPT code 32557.**

**May 2012 RUC Recommendations:**

The RUC recommendations for the codes in this family were considered by the RUC in April 2012 and submitted to CMS in May 2012. These recommendations are attached for informational purposes only.

**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.

**Practice Expense:**

Direct Practice expense inputs were approved by the RUC in April 2012 and were submitted to CMS in May 2012. Direct Practice expense is being resubmitted with this recommendation to reflect a modification to intraservice clinical staff time of two additional minutes for CPT code 32557, directly tied to physician intraservice time. The previous recommendations are attached to this recommendation for informational purposes only.

**Bladder Chemodenervation (Tab 5)**

**Thomas Cooper, MD; Christopher Gonzalez, MD; Norman Smith, MD; Thomas Turk, MD, Stephanie Klieb, MD (AUA)**

In February 2012, the CPT Panel created a new code, 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* to report physician work related to chemodenervation of the bladder. This procedure was previously reported using an unlisted code.

In April 2012, the RUC reviewed the survey results from 59 urologists and determined the survey respondents overestimated the physician work to perform this service. Additionally, there was consensus among the RUC that the survey median intra service time of 20 minutes was insufficient for a basic cystourethroscopy, which includes the work of CPT code 52000 (work RVU=2.23, intra service time=15 minutes) plus 30 injections. The RUC also agreed that this work was completely different than other chemodenervation treatments (e.g., migraine). The risks, including paralytic bladder, bleeding, perforation and urosepsis are significantly greater. The RUC reviewed 52007 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis* (work RVU=3.02) and determined that the physician work and intensity were similar. However, the RUC recommended that 52287 be resurveyed for the October 2012 to validate the intra service time and recommended an interim work RVU of 3.02, a direct crosswalk to CPT code 52007 for CPT code 52287.

In October 2012, the RUC reviewed the survey results from 125 urologists and noted that intra service time increased to 21 minutes, an increase in one minute from the previous survey results. When combined with the April 2012 survey results, the RUC determined that six additional minutes for the injections as described by CPT code 52287 was sufficient. Therefore, the RUC determined that an intra service time total of 21 minutes is appropriate for this service. The RUC also agreed that an additional five minutes of positioning time is required to place the patient in the dorsal lithotomy position, and ten minutes to account for scrub, dress and wait time is appropriate considering that the local anesthesia instilled in the bladder prior to the injections requires at least ten minutes to numb the bladder. There was consensus among the RUC that this service is more intense and complex than CPT code 52007 and should be valued higher. However, the RUC determined that the survey median of 5.18 and the 25<sup>th</sup> percentile work RVU of 4.18 overestimates the physician work.

The RUC reviewed CPT code 43250 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery* (work RVU=3.20) and agreed that the physician work, with identical intra-service times, and intensity between the surveyed code and the reference code were analogous. Therefore RUC agreed that a work value of 3.20 accurately accounts for the physician work involved in code 52287. To justify this value further, the RUC reviewed CPT code 16035 *Escharotomy; initial incision* (work RVU=3.74) and noted that while both codes have almost identical intra-service times, code 16035 has greater total time compared to the surveyed code, 70 minutes and 58 minutes, respectively. Finally, the RUC reviewed CPT code 15273 *Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children* (work RVU=3.50) and noted that both the

reference service and surveyed code have almost identical intra-service times and should be valued similarly. With these comparisons, the RUC agreed that a work RVU of 3.20 accurately values this service relative to other similar services across the RBRVS. **The RUC recommends a work RVU of 3.20 for CPT code 52287.**

**May 2012 RUC Recommendations:**

The RUC recommendation for this code was considered by the RUC in April 2012 and submitted to CMS in May 2012. This recommendation is attached for informational purposes only.

**Practice Expense:**

Direct Practice expense inputs were approved by the RUC in April 2012 and were submitted to CMS in May 2012. Direct Practice expense is being resubmitted with this recommendation to reflect a modification to intraservice clinical staff time of one additional minute, directly tied to physician intraservice time. The previous recommendations are attached to this recommendation for informational purposes only.

**Autonomic Function Testing (Tab 6)**

**Kevin Kerber, MD, (AAN); Thomas Chelimsky, MD (AAN)  
Facilitation Committee#1**

CPT codes 95921 and 95922 were identified through the Codes Reported Together 75% or More screen as well as the Different Performing Specialty from the Survey screen. In February 2012, the CPT Editorial Panel created a new code 95924 which combines the procedures currently described in 95921 and 95922 as these are currently reported together more than 75% of the time. Additionally, the utilization for 95921 and 95922 has dramatically increased from 2008 to 2009 and continues to rise, which the specialties attribute to incorrect reporting of these services for the use of a device for an automated nervous system test. Therefore, the CPT Editorial Panel created CPT 95943 to describe the automated nervous system test, in which providers do not use a tilt table during autonomic testing. In April 2012, the RUC reviewed the specialty recommendations for the five CPT codes and recommended work RVUs for three (95921, 95922 and 95923). The following two codes 95924 and 95943 were delayed to the October 2012 RUC meeting to ensure that adequate data was obtained to properly value these services.

***95924 Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt***

The RUC reviewed the survey results from 44 practicing physicians and agreed with the specialty societies that the survey median times of 15 minutes pre-service, 30 minutes intra-service and 15 minutes post-service accurately portray the physician time to perform the service. The RUC noted that CPT code 95924 bundles the work of two services: 95921 *Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio* (work RVU= 0.90, RUC recommended April 2012) and 95922 *Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt* (work RVU= 0.96, RUC recommended April 2012). Therefore, the RUC determined that a work RVU of 1.86, the combination of the two previous services, is inappropriate because it does not account for any efficiencies gained when the services are reported on the same day by the same physician.

To determine an appropriate work RVU, the RUC reviewed the survey's 25<sup>th</sup> percentile work RVU of 1.45 and determined that this work value was too low considering that the typical patient is more complicated and the bundled service is more intense when performed on the same date compared to when the two component services are performed alone. Therefore, the RUC reviewed CPT code 95813 *Electroencephalogram (EEG) extended monitoring; greater than 1 hour* (work RVU= 1.73) and agreed that with identical intra-service and total times, the two services should be valued identically. To justify this value, the RUC compared the surveyed code to CPT code 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU= 1.62) and agreed that since the reference code has less intra-service time compared to 95924, 20 minutes compared to 30 minutes, a work value of 1.73 appropriately values the surveyed code. Finally, the RUC compared the intensity for the services included in this bundled code to the two reference codes and determined that the recommended work value appropriately ranks this service compared to similar services. **The RUC recommends a work RVU of 1.73 for CPT code 95924.**

***95943 Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change***

In order to identify physicians who were performing this service the specialty societies, the American College of Physicians and the American Academy of Family Physicians, worked to obtain the equipment vendor's customer list as a way to identify physicians who could accurately value this service. ACP and AAFP also obtained random samples of physicians among their respective specialties. The specialties collected a total sample of 750 physicians and received approval from the Research Subcommittee to conduct a survey. However, only three partial responses were received, with no respondents indicating familiarity with the service. **Given this lack of data, the RUC continues to recommend carrier pricing for CPT code 95943.**

**May 2012 RUC Recommendations:**

The April 2012 RUC recommendations for CPT codes 95921, 95922 and 95923, submitted to CMS in May 2012, are attached to this recommendation for informational purposes only.

**Practice Expense:**

Direct Practice expense inputs were approved by the RUC in April 2012 and were submitted to CMS in May 2012. The previous recommendations are attached to this recommendation for informational purposes only.

**Bundle Thrombolysis (Tab 7)**

**Gary Seabrook, MD, (SVS); Robert Zwolak, MD, (SVS); Mathew Sideman, MD, (SVS); Michael Sutherland, MD, (SVS); Sean Roddy, MD, (SVS); Sean Tutton, MD, (SIR); Michael Hall, MD, (SIR); Robert Vogelzang, MD, (SIR); Jerry Niedzwiecki, MD, (SIR); Geraldine McGinty, MD, (ACR) and Zeke Silva, MD, (ACR)**

In 2010, the Relativity Assessment Workgroup identified two codes through the 75% reported together screen: 37201 *transcatheter therapy, infusion for thrombolysis other than coronary* and 75896 *transcatheter therapy, infusion, any method (eg thrombolysis other than coronary), radiological supervision and interpretation*. In October 2011, the CPT Editorial Panel created four new codes (37211-37214) to describe transcatheter therapy for thrombolysis bundled with radiologic supervision and interpretation and Evaluation and Management services. In January 2012, the specialty societies requested deferment of this family of services due to late CPT changes that expanded the number of codes; the continued questions about CPT guideline text, descriptors, and parentheticals; and the imprecision of the 000-day global survey instrument to accurately survey these codes. The Research Subcommittee approved a modified 000-day global survey instrument to be used to survey this family at the RUC meeting in April 2012. At the April 2012 RUC meeting, CPT codes 37211-37214 were reviewed and RUC recommendations were forwarded to CMS in May 2012. However, CPT codes 75896 *Transcatheter therapy, infusion other than for thrombolysis, radiological supervision and interpretation* and 75898 *Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis* were not surveyed and until specialty society recommendations were provided, the RUC recommended carrier pricing for both services.

At the October 2012 RUC meeting, the specialties reiterated to the RUC that under the current coding structure, CPT codes 75896 and 75898 are reported during thrombolytic therapy. However, with the CPT revisions for 2013, these two codes will no longer be reported during thrombolytic therapy. Given this, it is unknown exactly how these two orphan codes will be reported in 2013. The remaining non-thrombolysis use of these codes will be influenced by future CPT Editorial Panel changes. CPT code 75896 will be included in a multi-specialty coding revision effort led by neurosurgery. This coding proposal will describe intracranial infusion other than for thrombolysis (e.g. vasodilators in the setting of cerebral vasospasm). This coding change is expected to be reviewed by the CPT Editorial Panel in February 2013. CPT code 75898 will be addressed in the multi-specialty embolization coding revision due for CPT Editorial Panel review in February 2013 as well. The CPT codes resulting from these coding changes will be reviewed by the RUC at the April 2013 RUC meeting. **However, until recommendations are reviewed and submitted for 2014, the RUC continues to recommend carrier pricing for CPT codes 75896 and 75898.**

**May 2012 RUC Recommendations:**

The RUC recommendations for the other codes in this family were considered by the RUC in April 2012 and submitted to CMS in May 2012. These recommendations are attached for informational purposes only.

**Transitional Care Management Services (Tab 8)**

**Robert Zorowitz, MD (AGS), Thomas Weida (AAFP), Mary Newman, MD (ACP), Eileen Carlson, RN, JD (ANA), and Steven Krug, MD (AAP)**

In response to the July 2011 Notice of Proposed Rulemaking, the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee created the Chronic Care Coordination Workgroup (C3W) to specifically address the Centers for Medicare and Medicaid Services request to ensure that care coordination services were described and valued within the Evaluation and Management services. The C3W requested that CPT consider creation of codes to describe transitional care management and monthly complex chronic care coordination services. After many stakeholder meetings and as a result of discussions with CMS, in May 2012, the CPT Editorial Panel created two new codes to describe transitional care provided to patients from an inpatient setting to a home setting over a 30 day period. CPT codes 99495 *Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of at least moderate complexity during the service period, face-to-face visit, within 14 calendar days of discharge* and 99496 *Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of high complexity during the service period, face-to-face visit, within 7 calendar days of discharge* are unique Evaluation and Management services that include both face-to-face and significant non-face-to-face care delivered by the physician and the clinical staff over a 30 day period.

Transitional Care Management (TCM) is services delivered to patients who are transitioning from a facility to a non-facility care setting. The typical case is that of a patient transitioning from a hospital to home. Following a hospital discharge, TCM is a set of bundled face-to-face and non-face-to-face services performed by the physician or qualified health provider and clinical staff for the 30 days following discharge. The intent of TCM is to prevent re-hospitalization or emergency department visits. TCM is targeted to moderately or highly complex patients, with multiple co-morbidities, who take multiple medications and who are at high risk of deterioration. The service requires early and frequent communication with the patient, family, other providers and agencies over the month following hospital discharge to ensure that the discharge summary and appropriate clinical information is obtained quickly and reviewed, that the patient's medication and therapeutic regimen is reconciled and optimized and that all necessary clinical and community services are coordinated and delivered. In addition to these non face-to-face services, each code includes a timely face-to-face visit which typically occurs in the office, but can also occur at home or other location where the patient resides.

The non face-to-face services of TCM include communication with the patient and caregivers, communication with home health agencies, education to support self-management and activities of daily living, assessment of medication adherence and management, identification of community resources, facilitating access to care and services needed, obtaining and reviewing discharge information as available, reviewing need for or follow up on pending diagnostic tests, interaction with other qualified health care professionals, and the establishment of referrals and arranging for community resources.

TCM codes 99495 and 99496 have an XXX global period. All physician and staff time appear in the intra-service time because any services provided during the 30 day service period are, by definition, intra-service time. The CPT introductory language specifically describes the physician and clinical staff activities included in these services. The two significant differences between codes 99495 and 99496 are that 99496 requires **highly complex medical decision making** and a face-to-face visit must occur within **7 days** of discharge; whereas, CPT code 99495 requires **either moderate or highly complex medical decision making** and a face-to-face visit within **14 days** of discharge.

**99495 Transitional Care Management Services with the following required elements:**

- **Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge**
- **Medical decision making of at least moderate complexity during the service period**
- **Face-to-face visit, within 14 calendar days of discharge**

The RUC reviewed the survey results from 110 multi-specialty physicians and other qualified health care professionals for CPT code 99495. The RUC agreed with the survey respondents that the Evaluation and Management service that is most similar to the face-to-face portion of the TCM service to use as a proxy to understand the complexity of the patient is 99214. The RUC agreed that the survey median work RVU of 2.11 and 40 minutes of intra-service time appropriately account for the work required to perform the 30 days of transitional care services of CPT code 99495. The RUC compared 99495 to the key reference service, which was also 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50, 25 minutes intra-time, and 40 minutes total time). The RUC agreed with the specialty societies that the time related to the face-to-face portion of this service may be different from that of a typical 99214. The RUC determined that the complexity of caring for the typical patient is somewhere between an established patient and a new patient, due to the recent hospital stay of the patient. The RUC reviewed the correlation of physician time in relation to the clinical staff time and agreed with the specialty societies that the 75<sup>th</sup> percentile intra-time for clinical staff time (not including clinical staff time for the face-to-face visit) is 45 minutes. The clinical staff is required to clearly document what services they provide in order for this service to be reported. The RUC agreed that the physician non face-to-face time (estimated at 15 minutes) is largely spent addressing questions and supervising the clinical staff and there is not an overlap of transitional care services performed by the physician and the clinical staff.

The RUC determined that 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 2.43) is an appropriate key reference service because it is for a new patient and similarly for 99495, the patient's post discharge condition is unknown to the physician and is comparable to a new patient but is less intense. The RUC also compared 99495 to 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.20, 30 minutes intra-service and 40 minutes total time) and determined that 99495 requires similar total time but is more intense to perform than 74174. To support the median work RVU of 2.11 and intra-service time of 40 minutes the RUC compared 99495 to the services listed below, which require similar work, time and intensity. The relativity between code 99495 and these



services is appropriate. **The RUC recommends a work RVU of 2.11 and 40 minutes of intra-service time for CPT code 99495.**

**99496 Transitional Care Management Services with the following required elements:**

- **Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge**
- **Medical decision making of high complexity during the service period**
- **Face-to-face visit, within 7 calendar days of discharge**

The RUC reviewed the survey results from 110 multi-specialty physicians and other qualified health care professionals for CPT code 99496. The RUC agreed with the survey respondents that the Evaluation and Management service that is most similar to the face-to-face portion of the TCM service to use as a proxy to understand the complexity of the patient is 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11, 35 minutes intra-time and 55 minutes total time). The RUC agreed with the specialty societies that the time related to the face-to-face portion of this service may be different from that of a typical 99215. The RUC determined that the complexity of caring for the typical patient is somewhere between an established patient and a new patient, due to the recent hospital stay of the patient. The RUC reviewed the correlation of physician time in relation to the clinical staff time and agreed with the specialty societies that the 75<sup>th</sup> percentile intra-time for clinical staff time (not including clinical staff time for the face-to-face visit) is 60 minutes. The clinical staff time are required to clearly document what services they provide in order for this service to be reported. The RUC agreed that the physician non face-to-face time (estimated at 20 minutes) is largely spent addressing questions and supervising the clinical staff and there is not an overlap of transitional care services performed by the physician and the clinical staff.

The RUC agreed that the survey median work RVU of 3.05 and 60 minutes of intra-service time appropriately account for the work required to perform the 30 days of transitional care services of 99496. The RUC compared 99496 to the key reference service 90962 *End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month* (work RVU = 3.15 and 63 minutes intra-time) and noted that both services span a one month period and require similar physician time, 60 and 63 minutes respectively, all accounted for in the intra-service period.

The RUC also compared CPT code 99496 to 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17) which is reported for similar patients, whom require highly complex medical decision making. The RUC determined that 99205 is an appropriate key reference because it is for a new patient and similarly for 99496 the patient's post discharge condition is unknown to the physician and is comparable to a new patient but is less intense. For additional support, the RUC referenced CPT codes 77427 *Radiation treatment management, 5 treatments* (work RVU = 3.37) and 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour* (work RVU = 3.50), which require similar work, time and intensity. The

relativity between code 99496 and these services is appropriate. **The RUC recommends a work RVU of 3.05 and 60 minutes of intra-service time for CPT code 99496.**

**Practice Expense:**

The RUC reviewed the direct practice expense inputs and accepted the changes as modified by the Practice Expense Subcommittee. Specifically, any duplication between the clinical staff pre and post service time of the Evaluation/Management Service and the care coordination time was removed from the recommendations. The RUC also understands that electronic medical record systems are considered to be indirect costs and, therefore, these costs are not included in the direct cost recommendations.

**2013 Utilization Estimates:**

The specialty societies estimated the utilization for TCM to be approximately 2 million in the Medicare population, reflecting approximately 20% of all facility discharges. The specialties estimate that CPT code 99495 will be reported for Medicare patients 1,300,032 in 2013 and CPT code 99496 will be 866,688 times in 2013. Please see the attached word document and spreadsheet for detailed methodology on how the specialty societies arrived at these assumptions. Also, the RUC recommends that CMS consider for budget neutrality purposes that this reporting will be offset by decreases in the stand alone office visits that are bundled within the codes, as well as hospitalizations and emergency room visits that will be avoided. The detailed assumptions regarding these offsets are also attached in the spreadsheet provided.

**New Technology/New Services List**

The RUC noted that CPT codes 99495 and 99496 are new services and should be placed on the New Technology/New services list.

**Complex Chronic Care Coordination Services (Tab 9)**

**Robert Zorowitz, MD, (AGS); Thomas Weida, (AAFP); Mary Newman, MD, (ACP);**

**Eileen Carlson, RN, JD, (ANA); Steven Krug, MD, (AAP); and Joel Brill, MD, (AGA)**

In response to the July 2011 Notice of Proposed Rulemaking, the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee created the Chronic Care Coordination Workgroup (C3W) to specifically address the Centers for Medicare and Medicaid Services request to ensure that care coordination services were described and valued within the Evaluation and Management services. The C3W requested that CPT consider creation of codes to describe transitional care management and monthly complex chronic care coordination services. In May 2012, the CPT Editorial Panel created three new codes to describe complex chronic care coordination services that are patient centered management and support services. These services are provided by physicians and, other qualified health care professionals to an individual who resides at home or in a domiciliary, rest home or assisted living facility, per calendar month.

Complex chronic care coordination (CCCC) services are provided to patients who typically have multiple co-morbidities and frequently, multiple medications requiring ongoing non face-to-face care coordination, the choice of code is driven by the clinical staff time over the period of a calendar month. Unlike transitional care management (TCM) services, a recent hospital discharge is not required, but the typical patient has several chronic conditions, sees multiple care providers, requires a variety of therapeutic

and diagnostic services and has a management plan that requires frequent revisions. While the goal of TCM is to prevent re-hospitalization, the goal of CCCC is broader. The goals are to efficiently integrate care, maximize the patient's potential function and well-being and prevent hospitalization.

CPT code 99487 is reported for CCCC when there is no face-to-face visit during the calendar month. CPT Code 99488 is reported for CCCC when there is a face-to-face visit during the calendar month. Both CPT codes 99487 and 99488 specify 60 minutes of clinical staff time in the descriptor. Lastly, CPT code 99489 is an add-on code for each additional 30 minutes of clinical staff time for non face-to-face CCCC, which is reported with either codes 99487 or 99488.

CCCC codes 99487, 99488 and 99489 have an XXX global period. All physician and staff time appear in the intra-service time because any services provided during the 30 day service period are, by definition intra-service time. The CPT introductory language specifically describes the physician and clinical staff activities included in these services.

**99487 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month**

The RUC reviewed the survey results from 147 multi-specialty physicians and other qualified health care professionals for CPT code 99487. In order to maintain the proper rank order in relation to 99488 (described below), the specialty society indicated and the RUC agreed that the survey 25<sup>th</sup> percentile work RVU of 1.00 and 25<sup>th</sup> percentile time of 26 minutes are more accurate than the median survey results. The 25<sup>th</sup> percentile time also placed this service in the proper ratio compared to the clinical staff time of 60 minutes. The RUC compared 99487 to 99367 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician* (work RVU = 1.10 and 40 minutes total time) and determined that 99487 is slightly more intense to perform. The RUC compared 99487 to GXXXX3 *Coordination of care across all of a patient's healthcare needs, provided in a Tier 3 medical home, per month* (RUC Recommended work RVU = 0.35 for 9.2 minutes of service; or a weighted work RVU per minute of .0382) and determined that the work, time and intensity are almost identical, therefore computing a work RVU of 1.00. **The RUC recommends a work RVU of 1.00 and 26 minutes intra-service time for CPT code 99487.**

**99488 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month**

The RUC reviewed the survey results from 147 multi-specialty physicians and other qualified health care professionals for CPT code 99488. The RUC agreed with the survey respondents that the Evaluation and Management service that is most similar to the face-to-face portion of the CCCC service is 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11, 35 minutes intra- time, 55 minutes total time). CPT Code 99215 is used as a proxy to understand the complexity of the patient receiving the service. The RUC understands that the time of the face-to-face portion of this service may be different from that of a typical 99215. The RUC agreed that the survey median work RVU of 2.50 and 60 minutes of intra-service

time appropriately accounts for the work required to perform this office visit and the 30 days of complex chronic care coordination services of CPT code 99488.

The RUC compared CPT code 99488 to the key reference service 99350 *Home visit for the evaluation and management of an established patient* (work RVU = 3.28 and 75 minutes intra-service time) and determined that the work and time required to perform the reference service is higher due to higher intra-service time. The RUC compared the service to 99496 *Transitional Care Management services with high medical decision complexity; face-to-face visit within 7 days* (RUC recommended work RVU = 3.05 and 60 minutes intra-service time), also reviewed at this meeting. The RUC determined that the physician work required to perform 99488 is less intense than 99496 for two reasons: (1) the CCCC codes require moderate or highly complex medical decision making, whereas 99496 TCM, 7 days only requires highly complex medical decision making and (2) the patient's condition is well known to the physician due to ongoing CCCC. In the case of TCM codes, the patient's condition post-discharge is not known to the physician, making the patient similar to a new patient.

The RUC compared the 60 minutes median intra-service time in relation to the 107 minutes of total clinical staff time and determined that was appropriate. The RUC assumed the face-to-face portion of this service requires approximately 35 minutes, the same as 99215, which allows 25 minutes to perform the non face-to-face care over the calendar month.

To support the median work RVU of 2.50 and intra-service time of 60 minutes, the RUC compared 99488 to the services listed below, which require similar work, time and intensity. The relativity between code 99488 and these services is appropriate. **The RUC recommends a work RVU of 2.50 and 60 minutes of intra-service time for CPT code 99488.**

**99489 Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 147 multi-specialty physicians and other qualified health care professionals for CPT code 99489. In order to maintain the proper rank order in relation to 99487, the specialty society indicated, and the RUC agreed, that 99489 is half of the physician work and time. A work RVU of 0.50 and 13 minutes intra-service time place this service in the proper ratio compared to the clinical staff time of 30 minutes. The RUC compared 99489 to GXXXX3 *Coordination of care across all of a patient's healthcare needs, provided in a Tier 3 medical home, per month* (RUC Recommended work RVU = 0.35 for 9.2 minutes of service; or a weighted work RVU per minute of .0382) and determined that the work, time and intensity are almost identical, therefore computing a work RVU of 0.50. The RUC also compared 99489 to 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.48 and 10 minutes intra-service time) and determined that the work, time and intensity maintain the appropriate relativity. **The RUC recommends a work RVU of 0.50 and 13 minutes intra-service time for CPT code 99489.**

**2013 Utilization Estimates:**

The specialty societies indicated that the estimated utilization for these services will be approximately 9 million per year, representing 10% of all moderate to high complexity established office visits (99214 and 99215). The specialties also estimate that 55% of the CCCC services will be managed without a face-to-face visit using the code 99487. The estimates are projected to be: CPT code 99487 = 5,003,744, code 99488 = 3,730,064, and code 99489 = 363,909. It is estimated that fewer than 5% of patients will require in excess of 60 minutes of nurse manager non face-to-face time in one calendar month. The attached spreadsheet explains the methodology used by the specialty societies to arrive at these assumptions.

**New Technology/New Services List:**

The specialty society requests and the RUC agrees that CPT codes 99487, 99488, 99489 should be added to the new technology/new services list.

**Practice Expense:**

The RUC reviewed the direct practice expense inputs and accepted the changes as modified by the Practice Expense Subcommittee. Specifically, any duplication between the clinical staff pre and post service time of the Evaluation/Management Service and the care coordination time was removed from the recommendations. The RUC also understands that electronic medical record systems are considered to be indirect costs and, therefore, these costs are not included in the direct cost recommendations.

**IX. Relative Value Recommendations for CPT 2014:**

**Esophagoscopy (Tab 10)**

**Wayne Koch, MD (AAO-HNS)**

***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 (4321X1).

**Rigid Esophagoscopy Services**

The Otolaryngologists presented compelling evidence for the six rigid transoral esophagoscopy codes. There were two compelling evidence arguments given: a change in physician work due to technique and incorrect assumptions made at the time of the previous review. First, since these new procedures now refer only to rigid esophagoscopy procedures, the typical patient and typical provider of these services have changed from the previous codes that were either rigid or flexible. A rigid scope is only performed by a surgeon in the facility setting, under general anesthesia, since the typical patient is either a cancer patient or has a foreign body or other stricture that requires more intense work compared to a patient receiving a flexible esophagoscopy. Second, incorrect assumptions were made in the initial valuation of these services because Otolaryngologists were not surveyed. For three of the previously reported codes (43200, 43202 and 43215) only

Harvard values exist, in which Otolaryngologists were not consulted in the review process. For two of the previously reported codes (43220 and 43226) a RUC survey was completed but the vignette only specified flexible esophagoscopy. For the final previously reported service (43201) a RUC survey was performed by only Gastroenterologists completed the survey. Therefore, these new services as described, have never been properly valued to account for the typical provider and equipment. The RUC agreed with the compelling evidence that there is potential misvaluation for these services.

***4319X1 Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed***

The RUC reviewed the survey results from 59 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 51 minutes, intra-service time of 20 minutes and immediate post-service time of 15 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. Furthermore, 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25<sup>th</sup> percentile, 2.78 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78) and noted that while the reference code has 10 more minutes of intra-service time compared to 4319X1, the surveyed code has greater total time, 86 minutes compared to 65 minutes. Therefore, the RUC agreed that the recommended work RVU of 2.78 is appropriate for code 4319X1. To further justify this value, the RUC reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and noted that both the reference code and surveyed code have identical intra-service times and comparable physician work. Given these reference codes and compelling evidence that the previous work RVU for this service was misvalued, the RUC agreed that a work RVU of 2.78 accurately values 4319X1 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 2.78 for CPT code 4319X1.**

***4319X2 Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance***

The RUC reviewed the survey results from 31 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 56 minutes, intra-service time of 23 minutes and immediate post-service time of 20 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube. The RUC agreed that 5 additional minutes of evaluation time to prepare the injection is required for CPT code 4319X2 compared to code 4319X1.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25<sup>th</sup> percentile, 3.21 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that the reference code has 7 more minutes of intra-service time compared to 4319X2, and is slightly more intense, thus substantiating a slightly higher work value. To further justify a work RVU of 3.21, the RUC reviewed CPT code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (work RVU= 3.69) and agreed that with 7 additional minutes of intra-service time the reference code should be valued higher than 4319X2. Finally, the RUC compared 4319X2 to the diagnostic code 4319X1 and agreed that the increase of 3 minutes, 23 minutes compared to 20 minutes, in intra-service time for 4319X2 is accurate because of the additional time necessary to inject the wall of the esophagus. Furthermore, the addition of 5 minutes in the post-service period for 4319X2 is appropriate because these patients often have increased bleeding due to the injection and require more post-operative management compared to the diagnostic procedure. Given these reference codes and time differences, the RUC concurred that a work RVU of 3.21 accurately values 4319X2 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.21 for CPT code 4319X2.**

#### **4319X3 Esophagoscopy, rigid, transoral; with biopsy, single or multiple**

The RUC reviewed the survey results from 35 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 56 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube. The RUC agreed that 5 minutes of additional evaluation time to prepare the biopsy equipment is required for CPT code 4319X3 compared to code 4319X1.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25<sup>th</sup> percentile, 3.36 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both the reference code and the surveyed code have identical intra-service times and should be valued identically. To further justify a work RVU of 3.36, 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 intra-service times the two services should be valued similarly. Finally, the RUC compared 4319X3 to the injection code 4319X2 and agreed that 7 additional minutes, 30 minutes compared to 23 minutes, of in intra-service time is an accurate as several biopsies are taken to ensure an adequate sample and bleeding must be monitored. The specialty noted that this additional time is intense procedure time and not just waiting for an initial pathology report. Given these reference codes and time differences, the RUC concurred that a work RVU of 3.36 accurately values 4319X3 relative to both the family

of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.36 for CPT code 4319X3.**

***4319X4 Esophagoscopy, rigid, transoral; with removal of foreign body***

The RUC reviewed the survey results from 34 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 30 minutes and immediate post-service time of 28 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is very intense resulting from the emergent need to remove a large, sharp object from the patients' esophagus. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25<sup>th</sup> percentile, 3.99 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31638 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU= 4.88) and noted that while the reference code has more intra-service time than the surveyed code, 60 minutes compared to 30 minutes, the survey respondents indicated that code 4319X4 is more intense and complex procedure than code 31638. Therefore, the recommended work RVU of 3.99 for code 4319X4 is accurately valued in comparison to the reference code. To further justify this value, the RUC reviewed CPT code 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal* (work RVU= 4.00) and agreed that with identical intra-service time as the surveyed code, 30 minutes, the two codes should be valued similarly. Finally, the RUC compared 4319X4 to the other codes in the rigid esophagoscopy family and agreed that this emergent procedure requiring the removal of a foreign body is the most intense and complex procedure in the family because there is relatively little ramp up or ramp down in the intensity of physician work for this service. Given these reference codes, the RUC concurred that a work RVU of 3.99 accurately values 4319X4 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.99 for CPT code 4319X4.**

***4319X5 Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)***

The RUC reviewed the survey results and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is still intense and performed in the facility setting under general anesthesia. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to



similar services in the family of rigid esophagoscopy codes. To determine an appropriate value, the RUC compared code 4319X5 to 4319X2 (RUC recommended work RVU= 3.21) and noted that while 4319X5 has greater intra-service time compared to 4319X2, 30 minutes and 23 minutes, respectively, code 4319X5 has less total time in comparison. Therefore, the RUC agreed that these two services represent similar physician work and should both be valued at 3.21 work RVUs. To validate this work RVU, the RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both services have identical intra-service time, 30 minutes, and should be valued similarly. The RUC also reviewed CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and agreed that with identical intra-service and analogous total times, both codes should be valued similarly. **The RUC recommends a work RVU of 3.21 for CPT code 4319X5.**

**4319X6 Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire**

The RUC reviewed the survey results and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 33 minutes and immediate post-service time of 20 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is still intense and performed in the facility setting under general anesthesia. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to similar services in the family of rigid esophagoscopy codes. To determine an appropriate value, the RUC compared code 4319X6 to 4319X3 (RUC recommended work RVU= 3.36) and noted that while 4319X6 has slightly more intra-service time compared to 4319X2, 33 minutes and 30 minutes, respectively, code 4319X6 has less total time in comparison. Therefore, the RUC agreed that these two services represent similar physician work and should both be valued at 3.36 work RVUs. To validate this work RVU, the RUC compared 4319X6 to CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both 31625 and the surveyed code have similar intra-service times, 30 and 33 minutes, respectively, and should be valued identically. To further justify a work RVU of 3.36, 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 similar intra-service times, 30 and 33 minutes respectively, the two services should be valued similarly. **The RUC recommends a work RVU of 3.36 for CPT code 4319X6.**

### **Flexible Esophagoscopy Services- Transnasal**

#### ***4319X7 Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing or washing, when performed***

The RUC reviewed the survey results from 74 otolaryngologists and gastroenterologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 25 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC determined Package 6 Non-facility procedure with anesthesia was appropriate for this service with 2 additional minutes of scrub, dress, wait time to spray the topical anesthetic on the nostrils and then place and remove pledgets.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to the previous value for reporting this procedure, code 43200 (work RVU= 1.59). Therefore the RUC agreed with the specialty that the current work RVU of 1.59 is an appropriate value for code 4319X7. To justify this value, the RUC reviewed the key reference service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78) and noted that the reference code has double the intra-service time compared to the surveyed code, 30 minutes and 15 minutes, respectively. Therefore, the RUC agreed that the reference code should be valued higher and a work value of 1.59 for code 4319X7 maintains proper relativity with this similar service. The RUC also compared CPT code 62284 *Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)* (work RVU= 1.54) to the surveyed code and agreed that with identical intra-service time and analogous total times, these two codes should be valued similarly. **The RUC recommends and work RVU of 1.59 for CPT code 4319X7.**

#### ***4319X8 Esophagoscopy, flexible, transnasal; with biopsy, single or multiple***

The RUC reviewed the survey results from 75 otolaryngologists and gastroenterologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 25 minutes, intra-service time of 20 minutes and immediate post-service time of 10 minutes. The RUC determined Package 6 Non-facility procedure with anesthesia was appropriate for this service with 2 additional minutes of scrub, dress, wait time to spray the topical anesthetic on the nostrils and then place and remove pledgets.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to the previous value for reporting this procedure, code 43202 (work RVU= 1.89). Therefore the RUC agreed with the specialty that the current work RVU of 1.89 is an appropriate value for code 4319X8. To justify this value, the RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that reference code has 10 more minutes of intra-service time compared to the surveyed code. Therefore, the RUC agreed that the reference code should be valued higher and a work value of 1.89 for code 4319X8 maintains proper relativity with this similar service. The RUC also compared CPT code 57455 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix* (work RVU= 1.99) to the surveyed code and agreed that with identical intra-service time the two codes should be valued similarly. Finally, the RUC compared code 4319X8 to code 4319X7 and noted that the

additional work increment associated with 5 more intra-service minutes to perform the biopsy places 4319X8 in proper relativity to the family of services. **The RUC recommends a work RVU of 1.89 for CPT code 4319X8.**

### **Flexible Esophagoscopy Services- Transoral**

The specialties societies presented compelling evidence for the remaining flexible esophagoscopy family of services. There were two compelling evidence arguments given: a change in physician work since the last valuation and incorrect assumptions made during the last valuation. Physician work for these procedures used to be performed using fiberoptic instruments and it is now standard to use high-definition video endoscopes and high definition video monitors. Furthermore, during the previous valuation of these codes, there were no regulations and/or requirements for a complete history and physical of the patient within 30 days of the procedure now there are numerous documentation requirements (e.g. pre-sedation assessment and documentation of a comprehensive examination updated on the day of procedure) to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. Incorrect assumptions were also made during previous reviews of the codes. Since the adoption of pre-service time packages by the RUC in 2008 the physician work of moderate sedation is now captured in the pre-service work rather than the intra-service work. Additionally, the Harvard review and subsequent CMS review only included gastroenterologists, although otolaryngologists and general surgeons also perform these services. The RUC agreed with the compelling evidence that there is potential misvaluation for these services of codes.

Prior to reviewing the transoral flexible esophagoscopy family of services the specialty societies explained the survey methodology used to obtain physician time and RVU recommendations. In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required a standard survey be conducted of the new base code for flexible transoral esophagoscopy, 43200, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the RUC agreed with the same pre- and post- service times for all of the codes in 43201-43232 as for the revised base code for flexible trans-oral esophagoscopy, 43200.

The RUC observed that the specialty societies recommended two different pre-service time packages one for a straightforward patient and one for a more complex patient. However, neither of the specialties' recommendations is greater than the median survey times for each code. Therefore, while the pre-service packages change within the family, it is uniform and stays within the median response from the survey respondents. In addition, the specialty recommended that the median post-service time of 10 minutes inadequately accounts for the typical post-operative physician work. The RUC, however, noted that considering the high number of respondents, 121, the survey's median post-service time of 10 minutes should be standard throughout the series of codes.

### ***43200 Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed***

The RUC reviewed the survey results of 121 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time

components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes of pre-service time over the package is necessary to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that a work RVU of 1.59, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for 43200. To justify this value, the RUC reviewed MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina* (work RVU=1.50) and determined that while both the reference code and surveyed code have identical intra-service time, 43200 requires work because moderate sedation is inherent and should be valued higher than 57452. The RUC also reviewed 91035 *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation* (work RVU=1.59) and agreed that since both codes have similar intra-service and total times these services should be valued identically. **The RUC recommends a work RVU of 1.59 for CPT code 43200.**

**4321X1 Esophagoscopy, flexible, transoral; with optical endomicroscopy**

The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the survey median work RVU and 25<sup>th</sup> percentile work RVU both overstated the work included in this service. To determine an appropriate value, the RUC reviewed CPT code 12006 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm* (work RVU=2.39) and determined that, with identical intra-service time of 30 minutes, this service would require similar total physician work even though 4321X1 includes moderate sedation and 12006 includes local anesthesia. Therefore the RUC determined, and the specialty agreed, that a work RVU of 2.39, a direct crosswalk to code 12006, correctly ranks this new code to the base code 43200. In addition, the RUC considered that 4321X1 includes a diagnostic esophagoscopy followed by further diagnostic work utilizing an optical endomicroscope. This service is similar to two diagnostic services and that by applying the multiple procedure rule, would be equal to 2.39 work RVUs (1.59 + 1.59/2). **The RUC recommends a work RVU of 2.39 for CPT code 4321X1.**

**43201 Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance**

The RUC reviewed the survey results of 121 gastroenterologists gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC first discussed the difference in the current survey median intra-service time, 15 minutes, compared to the previous intra-service time of 25 minutes. The specialties explained that this time shift is due to the creation of pre-service time packages that has shifted the reporting of moderate sedation work from the intra-service to the pre-service. However, the RUC noted, and the specialties agreed, that the typical patient has changed from a patient with a stricture to a patient with achalasia and that the current value may not be appropriate. The RUC and the specialties also agreed that the current work RVU of 2.09 was too high and would create a rank order anomaly in this family of esophagoscopy codes. The RUC determined that although the times were the same as 43200, the intensity and complexity of work for 43201 would be greater and therefore the work RVU should be higher. To determine an accurate work value, the RUC reviewed MPC code 64483 *Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU=1.90) and code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU=1.90) and agreed that both reference codes and the surveyed code have identical intra-service time of 15 minutes, with similar total times. Therefore the RUC determined, and the specialty agreed, that a work RVU of 1.90, a direct crosswalk to CPT code 64483 and 54150, correctly ranks 43201 within the family of services. **The RUC recommends a work RVU of 1.90 for CPT code 43201.**

**43202 Esophagoscopy, flexible, transoral; with biopsy, single or multiple**

The RUC reviewed the survey results of 120 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the survey median work RVU and 25<sup>th</sup> percentile work RVU both overstated the work included in this service. The specialties argued and the RUC agreed that the work and time to perform this service has not changed and that 15 minutes of intra-time is appropriate. The RUC discussed the difference in the survey intra-service time compared to the current Harvard time and noted that it is due to the shift in reporting moderate sedation work in pre-service time rather than the intra-service time, as it was done before. Therefore, the current work RVU of 1.89 should be maintained for code 43202. To justify this value, the RUC reviewed MPC code 64483 *Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU=1.90) and code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU=1.90) and determined that since these codes have identical intra-service times, 15 minutes, and similar total time their work RVUs should be analogous. The RUC also reviewed code 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU= 2.00, 23/20/15) and determined that code 43202 was more complex due to moderate sedation, but was slightly less total work because of the intra-time difference. Finally, the RUC agreed that the work of code 43202 and 43201, with identical time components, should be valued similarly. **The RUC recommends a work RVU of 1.89 for CPT code 43202.**

**43204 Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices**

The RUC reviewed the survey results of 95 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the current work RVU of 3.76, the survey median, overestimated the physician work involved in this service. The RUC determined that a work RVU of 2.89, the survey 25<sup>th</sup> percentile, is an accurate measure of the physician work to perform code 43204. To justify this value, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and determined that the intensity and total physician work of 43204 is greater compared to the reference code because of a more complex patient. The RUC also noted that the higher intra-time in 31622 was due to moderate sedation work being included in the intra-time instead of pre-time component. In addition, the RUC reviewed code 49452 *Replacement of gastro-jejunoscopy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86) and noted that both codes have identical intra-service times and similar total times. The RUC reviewed code 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU=2.91, 12/15/10), which has less total time, but higher intensity than code 43204. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment and typically have decompensated liver disease, as described in the vignette. The specialties noted, and the RUC agreed, that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. **The RUC recommends a work RVU of 2.89 for CPT code 43204.**

**43205 *Esophagoscopy, flexible, transoral; with band ligation of esophageal varices***

The RUC reviewed the survey results of 108 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the current work RVU of 3.78, slightly above the survey median, overestimated the physician work involved in this service. The RUC determined that a work RVU of 3.00, the survey 25<sup>th</sup> percentile, is an accurate measure of the physician work to perform code 43205. To justify this value, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and determined that the intensity and total physician work of 43205 is greater compared to the reference code because of a more complex patient. The RUC also noted that the higher intra-time in 31622 was due to moderate sedation work being included in the intra-time instead of pre-time component. In addition, the RUC reviewed code 49452 *Replacement of gastro-jejunoscopy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86),

which has identical intra-service time compared to code 43205, but includes less intense guidance work. The RUC reviewed code 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU=2.91, 12/15/10), which has less total time, but higher intensity than code 43205. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment and typically have decompensated liver disease, as described in the vignette. The RUC determined that the difference in the current survey intra-time and previous RUC survey in 1993 is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. The RUC also compared the intensity difference between 43205 and 43204 and noted that the physician work was more intense for code 43205 due to increased complexity of banding varices in an actively bleeding patient. **The RUC recommends a work RVU of 3.00 for CPT code 43205.**

**43215 Esophagoscopy, flexible, transoral; with removal of foreign body**

The RUC reviewed the survey results of 102 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that patients undergoing sclerotherapy of esophageal varices are considered difficult because of the underlying comorbidities from cirrhosis, cancer, encephalopathy, and/or coagulopathy that are typical. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.60, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43215. To justify this value, the RUC reviewed three codes: MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU=2.70); CPT code 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* (work RVU=2.75) and CPT code 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU=2.70). Each of these reference codes have identical intra-service time, 20 minutes, compared to the surveyed code and provide ample support that the current work RVU of 2.60 accurately values code 43215 relative to services across the RBRVS. Finally, the RUC discussed the differences in Harvard time compared to the current survey time. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 20 minutes of intra-time is appropriate. The specialties noted that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. In addition, it was noted that the Harvard study did not include a typical patient and that code descriptor can represent a variety of foreign bodies. **The RUC recommends a work RVU of 2.60 for CPT code 43215.**

**43216 Esophagoscopy, 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 of 99 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-

service time of 33 minutes, intra-service time of 22 minutes and post-service time of 10 minutes. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 22 minutes of intra-time is appropriate. The specialties noted that the time data included in the RUC database is asterisked to "not use for validation of physician work." As described in the RUC rationale, the value for this code is based on independent work by CMS to value the increment and not on survey data. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.40, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43216. To justify this value, the RUC reviewed MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU=2.23) and noted that the reference code has 7 minutes less intra-service time compared to the surveyed code and should be valued less. The RUC also reviewed two additional codes that bracket the recommended work value for 43216: CPT code 45341 *Sigmoidoscopy, flexible; with endoscopic ultrasound examination* (work RVU=2.60, intra-service time= 30 minutes) and CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU=2.33, intra-service time= 20 minutes). Finally, the RUC compared code 43216 to code 43215, *flexible foreign body removal*, and agreed that while 43216 has 2 more minutes of intra-service time, the physician work is less intense and should be valued slightly less. The current work RVU of 2.40 is also relative to CPT code 43202, *flexible biopsy*, (RUC recommended work RVU= 1.89) as 43216 has 7 additional intra-service minutes. **The RUC recommends a work RVU of 2.40 for CPT code 43216.**

**43217 Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

The RUC reviewed the survey results of 90 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 30 minutes of intra-time is appropriate. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.90, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43217. To justify this value, the RUC reviewed MPC code 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 given both services have identical intra-service time, 30 minutes, both codes should have similar w/o *contrast injection(s), image documentation and report* (work RVU=2.86, intra-service time= 20 minutes) is a less intense procedure and should be valued slightly less and 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, intra-service time= 30 minutes) is a more intense procedure and should be valued higher than code 43217. Finally, the RUC noted that the recommended work value appropriately ranks



code 43217 to 43216, *flexible, lesion removal by hot biopsy*, as 43217 has 8 additional minutes of intra-service time. **The RUC recommends a work RVU of 2.90 for CPT code 43217.**

**43219 *Esophagoscopy, flexible, transoral; with insertion of plastic tube or stent***

The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The specialties noted that the previous RUC recommendations in both 1993 and 2000 were not accepted by CMS and therefore the time information in the RUC database is not directly correlated to the current work RVU. The specialties indicated, and the RUC agreed, that the current survey supports the current value and correctly relates both in time and intensity to the other codes in this esophagoscopy family. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the median level. Therefore, the RUC determined that a work RVU of 2.80, the current value and the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43219. To justify this value, the RUC reviewed CPT code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86) and noted that both services have identical intra-service time, 20 minutes, with analogous total time. Therefore both services should be valued similarly. The RUC also reviewed CPT code 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU=2.82) and discussed that while code 52332 has 5 more minutes of intra-service time, 43219 is a more intense procedure, with more total time, and should thus be valued almost identically to the reference code. Finally, the RUC compared 43219 to two other codes in the family with identical time components: 43204 *flexible with injection of varices* (RUC recommended work RVU= 2.89) and 43205 *flexible with band ligation* (RUC recommended work RVU= 3.00). In comparison to these procedure, 43219 should be valued slightly less than these other services because the physician work is less intense, as shown by the survey intensity/complexity measures. **The RUC recommends a work RVU of 2.80 for CPT code 43219.**

**43220 *Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)***

The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.10, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43220. To justify this value, the RUC reviewed CPT code 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU=2.20) and noted that both codes have identical intra-service

time, 20 minutes, and therefore should be valued similarly. The RUC also reviewed CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU=2.06) and agreed that while reference code has 5 minutes less intra-service time compared to 43220, the surveyed code has much greater total time and work values. The RUC also reviewed two codes that bracket the recommended work RVUs: CPT code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86, intra-service time= 20 minutes) is a less intense procedure and should be valued slightly less and 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, intra-service time= 30 minutes) is a more intense procedure and should be valued higher than code 43217. Finally, the RUC noted that the recommended work value appropriately ranks code 43217 to 43216, *flexible, lesion removal by hot biopsy*, as 43217 has 8 additional minutes of intra-service time. **The RUC recommends a work RVU of 2.90 for CPT code 43217.**

**43219 Esophagoscopy, flexible, transoral; with insertion of plastic tube or stent**

The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The specialties noted that the previous RUC recommendations in both 1993 and 2000 were not accepted by CMS and therefore the time information in the RUC database is not directly correlated to the current work RVU. The specialties indicated, and the RUC agreed, that the current survey supports the current value and correctly relates both in time and intensity to the other codes in this esophagoscopy family. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the median level. Therefore, the RUC determined that a work RVU of 2.80, the current value and the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43219. To justify this value, the RUC reviewed CPT code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86) and noted that both services have identical intra-service time, 20 minutes, with analogous total time. Therefore both services should be valued similarly. The RUC also reviewed CPT code 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* (work RVU=2.82) and discussed that while code 52332 has 5 more minutes of intra-service time, 43219 is a more intense procedure, with more total time, and should thus be valued almost identically to the reference code. Finally, the RUC compared 43219 to two other codes in the family with identical time components: 43204 *flexible with injection of varices* (RUC recommended work RVU= 2.89) and 43205 *flexible with band ligation* (RUC recommended work RVU= 3.00). In comparison to these procedure, 43219 should be valued slightly less than these other services because the physician work is less intense, as shown by the survey intensity/complexity measures. **The RUC recommends a work RVU of 2.80 for CPT code 43219.**

**43220 Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)**

The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.10, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43220. To justify this value, the RUC reviewed CPT code 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU=2.20) and noted that both codes have identical intra-service time, 20 minutes, and therefore should be valued similarly. The RUC also reviewed CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU=2.06) and agreed that while reference code has 5 minutes less intra-service time compared to 43220, the surveyed code has much greater total time and should be valued slightly higher. CPT code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 2.23) was also reviewed and the RUC agreed that with less total time compared to the surveyed code, 42 minutes and 57 minutes, respectively, the reference code is appropriately valued less than 43220. Finally, the RUC compared code 43220 to other similar codes in the family with 20 minutes of intra-service time and agreed that a work RVU of 2.10 accurately values this service relative to the other services. **The RUC recommends a work RVU of 2.10 for CPT code 43220.**

**43226 Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire**

The RUC reviewed the survey results of 114 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 25 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.34, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43226. To justify this value, the RUC reviewed CPT code 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00) and agreed that while both services have identical intra-service time, code 43226 is a more intense and complex procedure to perform and should be valued higher. In addition, the RUC reviewed CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU=2.33) and agreed that since the surveyed code has more intra-service time it should be valued slightly higher than the reference code. CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU= 2.06) was also reviewed and the RUC agreed that with less total time compared to the surveyed code, 43 minutes and 57 minutes, respectively, the reference code is appropriately valued less than 43226. Finally, code 43226 was compared to code 43220 *flexible with balloon dilation* (RUC recommended work RVU= 2.10) and the RUC agreed that 43226 should

be valued higher due to 5 more minutes of intra-service time. **The RUC recommends a work RVU of 2.34 for CPT code 43226.**

**43227 Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)**

The RUC reviewed the survey results of 87 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the median level. Therefore, the RUC determined that the survey 25<sup>th</sup> percentile work RVU of 3.26, less than the current value, is appropriate for CPT code 43226. To justify this value, the RUC reviewed CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU=3.36) and noted that both services have identical intra-service time, 30 minutes, and should be valued similarly. In addition, the RUC compared 43227 to CPT code 58555 *Hysteroscopy, diagnostic (separate procedure)* (work RVU=3.33) and agreed that while the reference code has 5 minutes less intra-service time, it has greater total time and should be valued slightly higher than code 43227. The RUC also reviewed MPC code 15002 *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, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU=3.65, intra= 20 minutes) and noted that although the surveyed code has 10 minutes more intra-service time, the reference code has much greater total time, 102 minutes compared to 73 minutes, and is appropriately valued higher than 43227. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment, as described in the vignette. The specialties noted, and the RUC agreed, that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. **The RUC recommends a work RVU of 3.26 for CPT code 43227.**

**43228 Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

The RUC reviewed the survey results of 54 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 35 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that patients undergoing sclerotherapy of esophageal varices are considered difficult because of the underlying co-morbidities from cirrhosis, cancer, encephalopathy, and/or coagulopathy that are typical. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the median level. Therefore, the RUC determined that the survey 25<sup>th</sup> percentile work RVU of 3.25, less than the current value,

is appropriate for CPT code 43228. To justify this value, 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU=3.36) and noted that while the surveyed code has 5 more minutes of intra-service time than 31625, the reference code is a more intense procedure and should be valued slightly higher. MPC code 15002 *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, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU=3.65) was also compared to the surveyed code and it was agreed that while both codes have similar work intensity, the reference code has greater total time, 105 minutes compared to 78 minutes, and is thus appropriately valued higher. In addition, the RUC reviewed CPT code 52007 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis* (work RVU= 3.02) and agreed that since the reference code has slightly less intra-service time compared to the surveyed code, 32.5 minutes and 35 minutes, respectively, code 43228 should be valued higher. To ensure relativity within the family, the RUC compared code 43228 to code 43227 *Flexible with control of bleeding* (RUC recommended work RVU= 3.26) and agreed that these two services are similar physician work and should be valued similarly. Finally, the specialties noted that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. **The RUC recommends a work RVU of 3.25 for CPT code 43228.**

**43231** *Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination*  
**43232** *Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)*

The RUC reviewed the survey data for CPT code 43232 and agreed with the specialty society that the survey respondents grossly underestimated the physician work and time involved in this service. The survey reports only median intra-service time of 15 minutes for 43232, while code 43232 represents the same service as 43231, median intra-service time of 45 minutes, with the addition of ultrasound guided fine needle aspiration/biopsy, and thus requires more time and more work. The RUC also noted that the survey respondents' median performance rate in the last year was zero. The specialties recommended, and the RUC agreed, that these two services should be re-surveyed for the January 2013 RUC meeting in conjunction with the upper gastrointestinal endoscopy codes that include ultrasound examination and/or ultrasound-guided treatment. **The RUC recommends CPT codes 43231 and 43232 be resurveyed and presented at the January 2013 RUC meeting.**

**Practice Expense:**

The PE Subcommittee reviewed the direct practice expense inputs recommended by the specialties and made modifications to the clinical staff times, medical supplies, and equipment items and time. In addition, several items listed as new equipment were reclassified as supplies with existing codes and equipment minutes were converted from units to minutes. The RUC accepted the direct practice expense inputs for these codes as modified by the Practice Expense Subcommittee.

**Molecular Pathology Workgroup -Tier 1 (Tab 11)**

**Jonathan Myles, MD, FCAP, (CAP); Aaron Bossler, MD, PhD,(CAP); and Roger Klein, MD, JD (CAP)**

The CPT Editorial Panel developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. This service is a new category I molecular pathology code and is among the last and lowest volume of the Tier 1 codes developed by the AMA CPT Molecular Pathology Coding Workgroup (MPCW). These services were previously reported with a series of “stacking codes.” The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS requested that the RUC review data provided by the College of American Pathologists to provide the Agency with more information as a policy is developed to determine which payment schedule is appropriate for these services.

At the September 2011 RUC meeting, the Molecular Pathology Tier 2 codes were valued and the specialty society crosswalked the values for low volume Tier 1 Molecular Pathology codes, with inadequate survey data, to the Tier 2 Molecular Pathology codes. This was done by comparing the exons requiring interpretation included in the Tier 2 level codes with the new Tier 1 code. CPT code 81161X *DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed* is a new Molecular Pathology Tier 1 code that is also a low volume service. The specialty society gained approval from the Research Subcommittee to base their work value recommendation on a direct crosswalk to a Tier 2 level code. The RUC agrees that this method will maintain relativity and rank order within the molecular pathology family of services.

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 CPT code 81407 *Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence* (RUC Recommended work RVU = 1.85) with 60 minutes of intra-service time. Code 81161X involves duplication/deletion analysis of the DMD gene which has 79 exons. Code 81407 also includes the “...analysis of duplication/deletion variants of > 50 exons” and requires 60 minutes of intra-service time. The RUC agreed that the physician time and work required to perform code 81407 should be accurately assimilated to the time and work of 81161X. The RUC also compared the surveyed service to 88323 *Consultation and report on referred material requiring preparation of slides* (work RVU=1.83, intra-time=56 minutes), and agreed that the reference code requires similar time to perform as compared to the surveyed code, 56 minutes and 60 minutes, respectively. **The RUC recommends a work RVU of 1.85 for CPT code 81161X.**

**New Technology/New Services List**

The RUC noted that CPT code 81161X, along with all the Molecular Pathology family of services, are new services and should be placed on the New Technology/New services list.

### **Practice Expense**

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

### **Immunohistochemistry (Tab 12)**

**Jonathan Myles, MD (CAP); and Michael McEachin, MD (CAP)**

In April 2011, the Relativity Assessment Workgroup (RAW) identified CPT code 88342 as a “CMS/Other” valued service with Medicare utilization of 500,000 or more. In addition, the code was identified by CMS as a High Expenditure Procedural code and in January 2012, the specialty society submitted an Action Plan to the RAW stating that referral to the CPT Editorial Panel was necessary. When CPT code 88342 was valued in 2003, the pathologist viewed one antibody per slide. However, since that review multiple antibodies can now be viewed per slide and the service was being reported for multiple units during the same session. Therefore, the College of American Pathologists (CAP) requested a CPT code change proposal to provide proper clarity to the service through a better definition of code 88342 and the establishment of a new add-on code 8834XX. The base code will now be reported once for the first separately identifiable antibody and the add-on service will be billed for each additional separately identifiable antibody thereafter.

#### ***88342 Immunohistochemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide***

The RUC reviewed the survey results from 198 pathologists and agreed with the specialty society that 20 minutes of intra-service time accurately accounts for the physician work involved in this service. The RUC then reviewed the survey respondents’ estimated work RVUs and agreed with the specialty that a work RVU of 0.60, the survey 25<sup>th</sup> percentile and less than the current work RVU of 0.80, is appropriate for CPT code 88342. To justify this value, the RUC reviewed the key reference service and MPC code 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU= 0.75) and agreed that the reference code should be valued higher than 88342 because it has 5 additional minutes of intra-service time, with similar intensity and complexity. In addition, the RUC compared the surveyed code to CPT code 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU= 0.62) and agreed that since both codes have identical intra-service time, 20 minutes, they should be valued similarly. **The RUC recommends a work RVU of 0.60 for CPT code 88342.**

#### ***8834XX Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide***

The RUC reviewed the survey results from 133 pathologists and agreed with the specialty society that 10 minutes of intra-service time accurately accounts for the physician work involved in this service. The RUC then reviewed the survey respondents’ estimated work RVUs and agreed with the specialty that the respondents’ 25<sup>th</sup> percentile work RVU of 0.56 is too similar to the work RVU, 0.60, of the base code. To determine an appropriate value for 8834XX, the RUC reviewed CPT code 88313 *Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry* (work RVU= 0.24) and agreed that both services have similar

physician work and intra-service time, 10 minutes and 13 minutes, respectively. Therefore, the RUC agreed that 8834XX should be directly crosswalked to the CPT code 88313, with a work RVU of 0.24, and the understanding that 8834XX is a more intense and complex service. The RUC also compared the surveyed code to CPT code 36405 *Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein* (work RVU= 0.31) and agreed that while both services have identical intra-service time, 10 minutes, the reference code has some pre and post time and should be valued higher than 8834XX. Finally, the RUC compared 8834XX to the base code 88342 and agreed that with half the intra-service time, 10 minutes compared to 20 minutes, 8834XX is appropriately valued at a work RVU of 0.24. **The RUC recommends a work RVU of 0.24 for CPT code 8834XX.**

**Practice Expense:**

The RUC accepted the direct practice expense inputs for all three CPT codes in the family as submitted by the specialty and approved by the Practice Expense Subcommittee.

**Work Neutrality:**

The RUC discussed the work neutrality impact of the new reporting structure. It is anticipated that the add-on service 8834XX will be billed 10% of the time with 88342. Since the typical scenario in which multiple antibodies would be reviewed in the same session involves the prostate, the specialty estimated 10% of immunohistochemistry services are reported concerning the prostate. Therefore, when providers previously billed multiple units of 88342 the resultant work RVU was 1.70 (0.85 x 2). Under the new reporting structure, this same service will receive 0.84 work RVUs (0.60 + 0.24). The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

**Anogenital Exam Colposcopy-PE Only (Tab 13)**

**Steve Krug, MD (AAP)**

In May 2012, this service was editorially revised by the CPT Editorial Panel to reflect change in practice due to new technology. The Practice Expense (PE) Subcommittee discussed the compelling evidence that the technique and knowledge/technology has changed significantly since the last review of this service. Best practice for this exam requires the use of highly trained support staff. The typical exam in a child advocacy center (nonfacility) now requires the expertise of clinical staff at the level of an RN and a specially trained Child Life Specialist (CLS). The PE Subcommittee determined that the specialty met compelling evidence and that the change and addition of clinical staff types are appropriate for this service. The RUC noted that Child Life Specialist is not recognized as a staff type in the CMS direct PE inputs clinical labor types list and is not listed as an occupation by the bureau of labor statistics. The specialty has included supporting documents regarding similar staff types in order to assist with appropriate pricing. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**



**Interprofessional Telephone Consultative Services (Tab 14)**

**Steve Krug, MD, FAAP, (AAP); Dennis Murray, MD, FAAP (AAP); Kevin Kerber, MD (AAN); Alfonso Bello, MD (ACRrh); Allan Glass, MD (TES); Howard Lando, MD (AACE)**

In June 2010, the CPT Editorial Panel created the Telephone Consultative Services Workgroup to address a proposal to create codes describing telephone/internet consultative services. The workgroup was charged with the following: Clarify use by non-physicians; Review the appropriateness of time increments for physician to patient calls; Clarify the typical patient/service descriptions based upon literature supplied; Consider appropriate use of term “consultation”; and Consider time interval for non-reporting as being distinct from a patient call (ie, if a face to face service occurs the next week or if co-management is in progress and the patient is seen every month, but more than 7 days previously, is the service reported). In May 2012, the CPT Editorial Panel approved a new Evaluation and Management subsection, guidelines and four codes to describe and report telephone/internet consultative services.

An interprofessional telephone/internet consultation is an assessment and management service in which a patient’s treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician/qualified health care professional in the diagnosis and/or management of the patient’s problem without the need for the patient’s face to face contact with the consulting physician.

These services are typically provided in complex and/or urgent situations where a timely face to face service with the consultant may not be feasible (eg, geographic distance). These codes should not be reported by a consultant who has agreed to accept transfer of care before the telephone/internet assessment, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial interprofessional telephone/Internet consultation.

The patient for whom the interprofessional telephone/internet consultation is requested may be either a new patient to the consulting physician or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face to face encounter within the last 14 days. When the telephone/internet consultation leads to an immediate transfer of care or other face-to-face service (eg, a surgery, hospital visit or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date by the consultative physician, these codes are not reported.

**994XX1 Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician/qualified healthcare professional; 5-10 minutes of medical consultative discussion and review**

The RUC reviewed the survey results from 48 multi-specialty physicians and determined that the survey respondents overestimated physician work. The specialty societies proposed and the RUC accepted modifications to the survey times to more accurately reflect the CPT descriptor: 3 minutes for pre-service; 8 minutes for intra service; and 5 minutes for post service. The RUC reviewed key reference service, CPT code 99441 *Telephone evaluation and management service provided by a physician to an established*

*patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion (work RVU=0.25) and agreed that 994XX1 is a more intense procedure. Typically, the patient is unknown to the consulting physician, the service is provided in a complex/urgent situation and the medical decision-making required is more intense than the key reference service. In order to maintain the proper rank order in relation to 994XX2 (described below), the RUC used magnitude estimation and determined that a work RVU between the survey 25<sup>th</sup> percentile (0.50) and the work RVU of 99441 (0.25) is appropriate. The RUC also compared 994XX1 to 99281 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor (work RVU = 0.45) and determined that 99281 is a more intense service and should be valued higher. The RUC recommends a work RVU of 0.35 for CPT code 994XX1.**

**994XX2 Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 11-20 minutes of medical consultative discussion and review**

The RUC reviewed the survey results from 31 multi-specialty physicians and determined that the survey respondents overestimated physician work. The specialty societies proposed and the RUC accepted modifications to the survey times to more accurately reflect the CPT descriptor: 3 minutes of pre-service; 15 minutes of intra service; and 5 minutes of post service. The RUC reviewed key reference service, 99442 *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion (work RVU=0.50) and agreed that 994XX2 is a more intense procedure. Typically, the patient is unknown to the consulting physician, the service is provided in a complex/urgent situation and the medical decision-making required is more intense than the key reference service. In order to maintain the proper rank order within the family of services, the specialty society indicated and the RUC agreed that a work of 0.70, lower than the survey 25<sup>th</sup> percentile is appropriate. The 0.35 increment increase in work RVU is similar to that within the telephone evaluation and management services, 99441-99443. The RUC also reviewed CPT code 99241 *Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family (work RVU = 0.64 and 15 minutes of intra-service time) and agreed that 994XX2 should be valued higher since it is typically provided in a complex/urgent situation. The RUC recommends a work RVU of 0.70 for CPT code 994XX2.**

**994XX3 Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 21-30 minutes of medical consultative discussion and review**

The RUC reviewed the survey results from 31 multi-specialty physicians and determined that the survey respondents overestimated physician work. The specialty societies proposed and the RUC accepted modifications to the survey times to more accurately reflect the CPT descriptor: 3 minutes for pre-service; 25 minutes for intra service; and 5 minutes of post service. The RUC reviewed CPT code 99443 *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion* (work RVU=0.75) and agreed that 994XX3 is a more intense procedure. Typically, the patient is unknown to the consulting physician, the service is provided in a complex/urgent situation and the medical decision-making required is more intense than the key reference service. In order to maintain the proper rank order within this family of services, the RUC used magnitude estimation and determined that a work RVU of 1.05 is appropriate (994XX2 work RVU of 0.70 + 0.35 = 1.05). The RUC compared 994XX3 to 99374 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker* (work RVU = 1.10) and determined that 99374 is a more intense service and should be valued higher. **The RUC recommends a work RVU of 1.05 for CPT code 994XX3.**

**994XX4 Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 31 minutes or more of medical consultative discussion and review**

The RUC reviewed the survey results from 26 multi-specialty physicians and determined that the survey respondents overestimated physician work. The RUC noted that 994XX4 will typically be utilized by behavioral/mental health professionals as there is a perceived need with access to care. The specialty societies proposed and the RUC accepted modifications to the survey times to more accurately reflect the CPT descriptor: 9 minutes for pre-service; 31 minutes for intra service; and 10 minutes for post service. The RUC reviewed CPT codes 92014 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits* (work RVU=1.42) and 99304 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.* (work RVU=1.64) and agreed that both services require less intra-service time and are more

intense than 994XX4. **The RUC recommends a work RVU of 1.40 for CPT code 994XX4.**

#### **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.

#### **Breath Hydrogen Methane Test-PE Only (Tab 15)**

**Edward Bentley, MD (ASGE); Nicholas Nickl, MD, (ASGE) and Joel Brill, MD, (AGA)**

In May 2012, this CPT code 91065 *Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)* (RVU = 0.20) was editorially revised by the CPT Editorial Panel to include measurement for hydrogen and methane levels. The CPT modification did not alter the physician work related to the interpretation. The majority, but not all of the population produce hydrogen gas. Approximately 15% of patients are methane producers rather than hydrogen producers, therefore each breath specimens must be measured for both hydrogen and methane levels. The RUC reviewed the specialty societies recommended direct practice expense inputs and revised the clinical staff time, medical supplies, and equipment to match standards established by the PE Subcommittee. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

### **X. CMS Requests – CMS High Expenditure Procedure Codes/Other**

#### **Open Treatment of Femoral Fracture (Tab 16)**

**William Creevy, MD; John Heiner, MD; David Halsey, MD; Mark Fromison, MD; Frank Voss, MD**

CPT code 27236 was identified by CMS through the High Expenditure Procedure Codes screen in the Medicare Proposed Rule for 2012. At the January 2012 RUC Meeting, the Relativity Assessment Workgroup (RAW) recommended a survey of physician work and practice expense for the October 2012 RUC Meeting.

#### ***27236 Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement***

The RUC reviewed the survey results from 117 orthopaedic and hip and knee surgeons and agreed with the specialty that the median survey times accurately reflect the physician work involved in this service. The following physician time components are recommended: 75 minutes of pre-service time, 90 minutes of intra-service time and 30 minutes of post-service time. Twelve additional minutes were added to the standard pre-service package to account for positioning the patient in the lateral decubitus position. The RUC also agreed with the specialty that the post-operative visits have not changed since the last RUC valuation in 2005 and are identical to the typical visits chosen by the survey respondents.

Prior to valuing the service, the RUC discussed the typical physician work involved for this service. First, the RUC noted that an Evaluation and Management code is not typically performed on the same date of service. The patient is typically admitted the day prior to the procedure with the initial hospital care provided. Second, the specialty

explained that while the work descriptor states that this procedure can be either internal fixation or prosthetic replacement, the typical patient undergoes replacement. Thus, the typical patient is older, less active, with more co-morbidities than a patient receiving fixation. Finally, the RUC discussed the physician work involved in the post-operative care of the patient, specifically, the share of work between the surgeon and the hospitalist or internist. The specialty explained that while there are co-management situations, the surgeon is heavily involved in many aspects of the post-management care of the patient, including: removal of sutures; evaluation of periodic imaging and laboratory reports, if needed; review of anticoagulation laboratory values and appropriate medication adjustment; and antibiotic and pain medication adjustments.

The RUC reviewed the survey respondents' estimated work values and agreed with the specialty that the respondents overestimated the physician work involved in this service. Given that there is no compelling evidence that the physician work has changed since the last valuation, the RUC recommends the current work RVU of 17.61, below the survey 25<sup>th</sup> percentile, for CPT code 27236. To justify this value, the RUC reviewed the key reference service CPT code 27244 *Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage* (work RVU= 18.18) and agreed that while the reference code has less intra-service time compared to code 27236, 75 minutes and 90 minutes, respectively, the reference code is a more intense procedure, with more total time, and should thus be valued slightly higher than the surveyed code. The RUC also compared 27236 to MPC code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU= 19.68) and agreed that the reference code is a more intense procedure with more intra-service time compared to the surveyed code, 103 minutes and 90 minutes, respectively. Therefore, the current work RVU of 17.61 accurately values the physician work for code 27236 in comparison to these reference codes. **The RUC recommends a work RVU of 17.61 for CPT code 27236.**

**Practice Expense:**

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

**Dilation of Esophagus (Tab 17)**

**Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Wayne M. Koch, MD (AAO-HNS), John Lanza, MD (AAO-HNS)**

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). The specialties also added the dilation of esophagus family of services (43450-43458) to ensure a comprehensive review of all the services is conducted.

The specialties societies presented compelling evidence that there has been a change in physician work for the dilation of esophagus codes. When these services were reviewed in the early 1990s conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry. Now in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In addition, during the previous valuation of these codes, there were no regulations and/or requirements for a complete history and physical of the

patient within 30 days of the procedure now there are numerous documentation requirements (e.g. pre-sedation assessment and documentation of a comprehensive examination updated on the day of procedure) to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. The RUC agreed with the compelling evidence that these codes are potentially misvalued.

**43450 *Dilation of esophagus, by unguided sound or bougie, single or multiple passes***

The RUC reviewed the survey results of 144 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 14 minutes. The RUC agreed with the specialties that two additional minutes of pre-service time over the package is necessary to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the estimates were overvalued. Therefore, the RUC recommends the current work RVU of 1.38, slightly less than the survey 25<sup>th</sup> percentile, for CPT code 43450. To justify this value, the RUC reviewed CPT code 57410 *Pelvic examination under anesthesia (other than local)* (work RVU= 1.75) and agreed that while both services have identical intra-service time, 15 minutes, the reference code has greater total time and should thus be valued higher than 43450. In addition, the RUC also reviewed two additional reference codes: CPT code 64446 *Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.81) and CPT code 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU= 1.73). The RUC noted that both these reference codes have comparable work and total times, however each code has 5 minutes more intra-service time compared to 43450 and should thus be valued higher than the surveyed code. **The RUC recommends a work RVU of 1.38 for CPT code 43450.**

**43453 *Dilation of esophagus, over guide wire***

The RUC reviewed the survey results of 141 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 20 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that two additional minutes of pre-service time over the package is necessary to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the estimates were overvalued. Therefore, the RUC recommends the current work RVU of 1.51, much less than the survey 25<sup>th</sup> percentile, for CPT code 43453. To justify this value, the RUC reviewed CPT code 64446 *Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.81) and agreed that while both services have identical intra-service time, 20 minutes, the reference code is a slightly more complex service and should be valued higher than 43453. In addition, the RUC reviewed CPT code 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU= 1.73) and agreed that while both services have identical intra-service time, 20 minutes, the reference code is a slightly more complex service and should be valued higher than surveyed code. Finally, the RUC compared CPT code 43453 to code 43450 (RUC recommended work RVU= 1.38) and agreed that a work RVU of 1.51 for code 43453 is appropriate given

that it has 5 additional minutes of intra-service time compared to 43450. **The RUC recommends a work RVU of 1.51 for CPT code 43453.**

***43456 Dilation of esophagus, by balloon or dilator, retrograde***

***43458 Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia***

The specialty societies in preparation of surveying these services for the RUC noted that both CPT codes 43456 and 43458 are most typically performed with endoscopy with and without fluoroscopy. The specialties and RUC agreed that further refinement of the code descriptors and parentheticals is warranted to clarify the typical reporting of these services. The specialties will submit a Code Change Proposal to the CPT Editorial Panel for review at the October 2012 meeting and will conduct surveys and prepare recommendations for the January 2013 RUC meeting. **The RUC recommends CPT codes 43456 and 43458 be referred to the CPT Editorial Panel.**

**Practice Expense:**

The PE Subcommittee reviewed the direct practice expense inputs recommended by the specialties and made modifications to the clinical staff times, medical supplies, and equipment items and time. The RUC accepted the direct practice expense inputs for these codes as modified by the Practice Expense Subcommittee.

**Spine Injections (Tab 18)**

**Fred Davis, MD; Joseph Zuhosky, MD; Barry Smith, MD; Marc Leib, MD; Richard Rosenquist, MD; Christopher Merifield, MD; William Sullivan, MD AAPM, AAPM&R, ASA, ASIPP, ISIS, NASS**

***Facilitation Committee #2***

In the NPRM for 2012, CMS identified CPT code 62311 *Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal) through the CMS High Expenditure Procedural Codes screen.* The RUC recommended survey of physician work and review of practice expense for this spine injection family.

***62310 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic***

The RUC reviewed the survey results from 76 anesthesiologists for CPT code 62310. The respondents indicated a median work RVU of 2.25, well above the current work RVU of 1.91. The RUC did not believe there was compelling evidence that the work has changed, and noted that the current work value, although lower than the survey 25<sup>th</sup> percentile, is too high. Prior to valuing the service, the RUC noted that the surveyed physician time, 20 minutes pre-, 11 minutes intra- and 10 minutes immediate post-service time, is lower than the current time, which was last surveyed by the RUC in 1999. In order to understand the discrepancy in survey time the RUC determined that the higher physician time components surveyed in 1999 were an outlier when compared to the previously reported code's original Harvard total time of 42 minutes. The specialty explained and the RUC agreed that the surveyed physician time appropriately accounts for the time required to perform this procedure. To determine a revised work RVU, the RUC used magnitude estimation to ensure that the work value is accurate and relative to other services. The

RUC determined that the relativity of 62310 can be valued using the ratio of the work value for a lumbar catheter placement to the work value for a cervical catheter placement. The RUC used the recommended values of 62318 *inject spine with cath C/T* (RUC recommended work RVU = 2.04) and 62319 *inject spine with cath C/T L/S* (CD) (RUC recommended work RVU = 1.87) to develop the ratio and then applied that to the lumbar code 62311 *inject spine L/S* (CD) (RUC recommended work RVU = 1.54)

$$\begin{aligned} 2.04/1.87 &= 1.09 \\ 1.09 \times 1.54 &= 1.68 \end{aligned}$$

For additional support, the RUC determined that the relativity of 62310 can be valued using the ratio of the work value for the service with and without a catheter placement. The committee used the recommended values of 62311 *inject spine L/S* (CD) (RUC recommended work RVU = 1.54) and 62319 *inject spine with cath C/T L/S* (CD) (RUC recommended work RVU = 1.87) to develop the ratio and then applied that to the cervical injection code 62318 *inject spine with cath C/T* (RUC recommended work RVU = 2.04).

$$\begin{aligned} 1.54/1.87 &= 0.824 \\ 0.824 \times 2.04 &= 1.68 \end{aligned}$$

To ensure that the magnitude estimation is correct the RUC compared the surveyed code to 53620 *Dilation of urethral stricture by passage of filiform and follower, male; initial* (work RVU=1.62, 10 minutes intra-service time). The RUC noted that 53620 and the surveyed code have almost identical intra-service time, however the total time is less justifying the slightly lower value for 53620. To further support the value of 1.68 for 62310 the RUC compared the surveyed code to CPT code 45307

*Proctosigmoidoscopy, rigid; with removal of foreign body* (work RVU = 1.70, 15 minutes intra-service time). The RUC noted that the time and intensity are slightly higher for the comparison code, justifying the slightly higher value. According to 2010 Medicare data 62310 is billed with CPT code 77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)* (work RVU = 0.60) in 52% of the time that this service is utilized. The RUC discussed the potential for overlap in physician work or practice expense clinical staff time, but upon further review determined that there was no overlap. **The RUC recommends a work RVU of 1.68 for CPT code 62310.**

**62311 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

The RUC reviewed the survey results from 63 anesthesiologists for CPT code 62311 and determined that the recommendation of no change to the work value is appropriate based on other procedures that are 000 day globals with the same intra-service time. The RUC recommended maintaining the current work RVU of 1.54 for CPT code 62311. The RUC agreed that the surveyed physician time of 20 minutes pre-, 10 minutes intra- and 10 minutes immediate post-service time appropriately account for the time required to perform this procedure. The RUC compared the surveyed code 62311 to 58100 *Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without*



*cervical dilation, any method (separate procedure)* (work RVU=1.53, 10 minutes intra), and noted that both the reference code and surveyed code have identical intra-service times and comparable physician work. To further justify a work RVU of 1.54, the RUC compared the surveyed code to key reference service CPT code 64483 *Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90 and 15 minutes intra-service time), and noted that the reference code has 5 more minutes of intra-service time compared to 62311, and is slightly more intense, thus substantiating a higher work value. **The RUC recommends a work RVU of 1.54 for CPT code 62311.**

**62318** *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic*

The RUC reviewed the survey results from 35 anesthesiologists for CPT code 62318 and determined that the recommendation of no change to the work value is appropriate based on other procedures that are 000 day globals with the same intra-service time. The RUC recommended maintaining the current work RVU of 2.04 for CPT code 62318. The RUC agreed that the surveyed physician time of 20 minutes pre-, 15 minutes intra- and 15 minutes immediate post-service time appropriately account for the time required to perform this procedure. The RUC compared the surveyed code 62318 to 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU=2.06, 15 minutes intra), and noted that both the reference code and surveyed code have identical intra-service times and comparable physician work. To further justify a work RVU of 2.04, the RUC compared the surveyed code to key reference service CPT code 64479 *Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU=2.29, 15 minutes intra) and 52000 *Cystourethroscopy (separate procedure)* (Work RVU=2.23, 15 minutes intra), and noted that both the reference code and surveyed code have identical intra-service times and comparable physician work. **The RUC recommends a work RVU of 2.04 for CPT code 62318.**

**62319** *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)*

The RUC reviewed the survey results from 33 anesthesiologists for CPT code 62319 and determined that the recommendation of no change to the work value is appropriate based on other procedures that are 000 day globals with the same intra-service time. The RUC recommended maintaining the current work RVU of 1.87 for CPT code 62319. The RUC agreed that the surveyed physician time of 20 minutes pre-, 15 minutes intra- and 15 minutes immediate post-service time appropriately account for the time required to perform this procedure. The RUC compared the surveyed code 62319 to 15275 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area* (work RVU=1.83, 15 minutes intra) and noted that both the reference code and surveyed code have identical intra-service times and comparable physician work. To further justify a work Ruff 2.04, the RUC compared the surveyed code to key reference service CPT code 36556 *Insertion of non-tunneled*

*centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50, 15 minutes intra) and 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU=1.90, 15 minutes intra), and noted that both the reference code and surveyed code have identical intra-service times and comparable physician work. **The RUC recommends a work RVU of 1.87 for CPT code 62319.**

**Practice Expense:**

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

**Work Neutrality:**

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

**CT Head/Brain (Tab 19)**

**Gregory Nicola, MD (ASNR) Joshua Hirsch, MD (ASNR)**

CPT code 70450 was identified by the CMS High Expenditure Procedural Codes and the CMS/Other with utilization over 500,000 screens. In January 2012, the Relativity Assessment Workgroup recommended that the specialties survey both 70450 and 70460 for the October 2012 RUC Meeting.

***70450 Computed tomography, head or brain; without contrast material***

The RUC reviewed the survey results from 92 radiologists and neuroradiologists and recommend the following median survey time components: 4 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. The RUC discussed with the specialties the need for review of prior studies in both the pre-service and intra-service time components. The specialties explained that in the pre-service time a review of prior studies is essential in communicating proper protocol with the technologist and to confirm the appropriateness of the study. In the intra-service time a review of prior studies is also performed during the interpretation in order to make comparisons between previous scans and the new scan. Finally, the RUC noted that while 64 slice CT scanners are now common in practice settings, the CMS CT room practice expense pricing is based on using a 16 slice scanner. However, the specialties clarified that the physician work and time would not vary between the two technologies. Therefore, the value for CPT code 70450 should be based on a 16 slice scanner.

The RUC reviewed the survey respondents' estimated work values and agreed with the specialties that a work RVU of 0.85, the current work value and below the survey 25<sup>th</sup> percentile, is appropriate for CPT code 70450. To justify this value, the RUC reviewed the key reference service CPT code 72125 *Computed tomography, cervical spine; without contrast material* (work RVU= 1.07) and noted that the reference code has 5 additional minutes of intra-service time compared to 70450, 15 minutes and 10 minutes, respectively. Accordingly, the RUC determined a work RVU of 0.85 accurately values 70450 in comparison to this similar reference service. In addition, CPT code 72192 *Computed tomography, pelvis; without contrast material* (work RVU= 1.09) was compared to the surveyed code and the RUC agreed that while both services have identical intra-service time of 10 minutes, the reference code should be valued higher because of greater intensity and complexity. The RUC also reviewed radiology codes outside the CT family and determined that MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81), with identical intra-service

time as code 70450, should be valued similarly. **The RUC recommends a work RVU of 0.85 for CPT code 70450.**

**70460 Computed tomography, head or brain; with contrast material**

The RUC reviewed the survey results from 92 radiologists and neuroradiologists and recommends the following median survey time components: 5 minutes of pre-service time, 12 minutes of intra-service time and 5 minutes of post-service time. The RUC discussed with the specialties the need for review of prior studies in both the pre-service and intra-service time components. The specialties explained that in the pre-service time a review of prior studies is essential to communicate proper protocol with the technologist and to confirm the appropriateness of the study. In the intra-service time a review of prior studies is also performed during the interpretation in order to make comparisons between previous scans and the new scan. Finally, the RUC noted that while 64 slice CT scanners are now common in practice settings, the CMS CT room practice expense pricing is based on using a 16 slice scanner. However, the specialties clarified the service physician work and time would not vary between the two technologies. Therefore, the value for CPT code 70460 should be based on a 16 slice scanner.

The RUC reviewed the survey respondents' estimated work values and agreed with the specialties that a work RVU of 1.13, the current work value and below the survey 25<sup>th</sup> percentile, is appropriate for CPT code 70460. To justify this value, the RUC reviewed the key reference service CPT code 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU= 1.27) and agreed that since the reference code has 3 additional minutes of intra-service time compared to 70460, 15 minutes compared to 12 minutes, 74160 should be valued higher. Additional support comes from CPT code 71260 *Computed tomography, thorax; with contrast material(s)* (work RVU= 1.24) which, like the key reference service, has 3 additional minutes of intra-service and is accurately valued greater than 70460. Finally, the RUC compared the surveyed code to CPT code 78306 *Bone and/or joint imaging; whole body* (work RVU= 0.86) and noted that the reference code has 4 minutes less intra-service time, 8 minutes, compared to code 70460. The RUC agreed that the recommended work value of 1.13 for 70460 is appropriately valued higher than this reference code. **The RUC recommends a work RVU of 1.13 for CPT code 70460.**

**Practice Expense:**

The PE Subcommittee discussed CMS' refinement (PFS 2012) to the equipment minutes for CT room for CPT code 70470 from the RUC recommendation of 42 minutes to 30 minutes. The specialty explained and the PE Subcommittee agreed that the CT room is in use and not available for another patient during the entirety of the service period and that 30 minutes equipment time for this service is not appropriate. Furthermore the PE Subcommittee determined that it would cause a rank order anomaly for practice expense equipment time within the family of codes. The RUC accepted the direct practice expense inputs for all three CPT codes in the family as submitted by the specialty and approved by the Practice Expense Subcommittee.

**Electrocardiogram (Tab 20)**

**Richard Wright, MD (AAC); Mary Newman, MD (ACP); Thomas Weida, MD (AAFP)**

In the NPRM for 2012, CMS identified CPT code 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* through the CMS High

Expenditure Procedural Codes screen. The RUC added CPT codes 93005 *Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report* and 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* as part of this family. The specialty societies indicated that these codes are unique in that 93005 describes the technical component only, 93010 describes the professional component only and 93000 describes the global service. The specialties surveyed the physician work for the professional service 93010 and updated the practice expense inputs for 93005 and recommended the combined work and practice expense of these two services for 93000.

**93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only***

The RUC reviewed survey responses from 52 cardiologists, family physicians and internal medicine physicians for CPT code 93010 and agreed with the specialty societies that although the survey respondents indicated that this service requires more physician work than it is currently valued, there is no compelling evidence that the physician work has changed. The specialty societies indicated and the RUC agreed that there is a computerized report; however, 35% of ECG computer interpretations are incorrect and the physician must over-read 100% of computer-interpreted electrocardiograms for inconsistencies and to ensure the results are interpreted correctly. The RUC agreed with the specialty societies that this service is not just an automated test. The RUC agreed with the survey median intra-service time of 5 minutes. The physician work required to perform this service includes:

- reviewing and comparing the ECG computer interpretation and adjusting for age, weight, body habitus, gender and known cardiac diagnoses and effect of electronic cardiac devices if present;
- inspecting ECG for rhythm, including assessment of atrial and ventricular rates and rhythms, and the summation of those two rhythms as the patient's intrinsic rhythm;
- measuring primary intervals and comparing them to computer generated intervals, if available, and intervals from previous ECG's (these intervals include: PR, QRS duration, QT duration, and others);
- analyzing and comparing the P wave morphology and axis, and the QRS axis;
- analyzing the QRS morphology in comparison to previous ECG's, assessing criteria for voltage, myocardial infarction, hypertrophy, and presence of early or altered depolarization;
- analyzing the ST segments and T waves for evidence of ischemia, infarction, pericarditis, or repolarization abnormalities;
- inspecting each tracing for the presence or absence of pacemaker impulses or artifacts; reviewing and comparing current ECG to one or more previous ECG; and
- comparing physicians' ECG interpretation with that obtained from the computer ECG analysis, if available, and then deleting and/or including appropriate diagnoses.

The RUC noted that this service includes the interpretation of confusing previous tracings, and if the ECG is not interpreted properly, the implications of an abnormal ECG are enormous, as a significant number of tests must then be performed.

The RUC compared 93010 to CPT code 94010 *Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without*

*maximal voluntary ventilation* (work RVU = 0.17 and 5 minutes intra-service time) and noted that 93010 is more difficult than 94010. An ECG requires more background and has a higher intensity because an ECG could indicate that a patient is experiencing an acute myocardial infarction or an arrhythmia that requires immediate attention, whereas that circumstance would never occur when performing a spirometry. However, the survey respondents indicated and the RUC agreed that these services require the same physician work and time. For further support, the RUC referenced similar services CPT code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (work RVU = 0.17 and 7 minutes intra-service time) and 73560 *Radiologic examination, knee; 1 or 2 views* (work RVU = 0.17 and 3 minutes intra-service time) and agreed that 93010 is appropriately valued relative to these reference codes. **The RUC recommends a work RVU of 0.17 for CPT code 93010.**

**93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report***

The RUC reviewed CPT code 93000 and noted that this service describes the global service, including both physician work and practice expense. The RUC recommends the same work RVU of 0.17 and 5 minutes intra-service time and 1 minute immediate post-service time as the professional component only CPT code 93010.

The specialty societies indicated and the RUC agreed that there is a computerized report, however, 35% of ECG computer interpretations are incorrect and the physician must over-read 100% of computer-interpreted electrocardiograms for inconsistencies and to ensure the results are interpreted correctly. The RUC agreed with the specialty societies that this service is not just an automated test. The RUC agreed with the survey median intra-service time of 5 minutes. The physician work required to perform this service includes:

- reviewing and comparing the ECG computer interpretation and adjusting for age, weight, body habitus, gender and known cardiac diagnoses and effect of electronic cardiac devices if present;
- inspecting ECG for rhythm, including assessment of atrial and ventricular rates and rhythms, and the summation of those two rhythms as the patient's intrinsic rhythm;
- measuring primary intervals and comparing to computer generated intervals, if available, and intervals from previous ECG's (these intervals include: PR, QRS duration, QT duration, and others);
- analyzing and comparing the P wave morphology and axis, and the QRS axis;
- analyzing the QRS morphology in comparison to previous ECG's, assessing criteria for voltage, myocardial infarction, hypertrophy, and presence of early or altered depolarization;
- analyzing the ST segments and T waves for evidence of ischemia, infarction, pericarditis, or repolarization abnormalities;
- inspecting each tracing for the presence or absence of pacemaker impulses or artifacts; reviewing and comparing current ECG to one or more previous ECG; and
- comparing physicians' ECG interpretation with that obtained from the computer ECG analysis, if available, and then deleting and/or including appropriate diagnoses.

The RUC noted that this service includes the interpretation of confusing previous tracings, and if the ECG is not interpreted properly, the implications of an abnormal ECG are enormous, as a significant number of tests must then be performed.

The RUC compared 93000 to CPT code 94010 *Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation* (work RVU = 0.17 and 5 minutes intra-service time) and noted that 93000 is more difficult than 94010. An ECG requires more background and has higher intensity because an ECG could indicate that a patient is experiencing an acute myocardial infarction or an arrhythmia that requires immediate attention, whereas that circumstance would never occur when performing a spirometry. However, the survey respondents indicated and the RUC agreed that these services require the same physician work and time. For further support, the RUC referenced similar services CPT code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (work RVU = 0.17 and 7 minutes intra-service time) and 73560 *Radiologic examination, knee; 1 or 2 views* (work RVU = 0.17 and 3 minutes intra-service time) and agreed that 93000 is appropriately valued relative to these reference codes. **The RUC recommends a work RVU of 0.17 for CPT code 93000.**

**Practice Expense:**

The Practice Expense Subcommittee modified the direct practice expense inputs for CPT codes 93000 and 93005 by reducing the clinical staff time and removing the 2 minutes for obtaining consent, because consent is not required to perform an ECG. The RUC accepted the direct practice expense inputs for these codes as modified by the Practice Expense Subcommittee.

**Extracranial Studies (Tab 21)**

**Gary Seabrook, MD (SVS); Robert Zwolak, MD (SVS); Mathew Sideman, MD, (SVS); Michael Sutherland, MD, (SVS); Zeke Silva, MD, (ACR) and Richard Wright, MD, (ACC)**

In the July 19, 2011 Proposed Rule for 2012, CMS requests that the RUC review a list of 70 high expenditure procedural codes. CPT code 93880 was included on the list. In January 2012, the Relativity Assessment Workgroup (RAW) reviewed the specialties' Action Plan and agreed to survey CPT codes 93880 and 93882.

The specialty societies presented compelling evidence that these codes are currently misvalued. First, there has been a change in the physician work since the last valuation as part of the First Five-Year Review in 1995. There are much more complex, detailed practice guidelines established for these procedures since 1995. The Intersocietal Commission for Accreditation of Vascular Laboratories (ICAVL) has published an extensive list of B-mode, color Doppler and Doppler waveform analysis and the 93880 exam must now evaluate sites of endovascular interventions that were essentially never performed in any significant volume 25 years ago, but are common now. In addition, previously colorflow technology did not have wide commercial availability, and ultrasound technology had insufficient sensitivity to evaluate arterial wall characteristics and plaque morphology. Compared to review of static images printed on x-ray film, new video archiving technology provides for the interpretation of more images, more sophisticated velocity waveforms, and more post-processing of the acquired data. Finally, the dominant specialty has changed. In 1995 Radiology presented this code to the RUC.

At that time the dominant provider was radiology, accounting for 40% of the total Medicare claims for this service (global + -26), and neither Cardiology or Vascular Surgery were involved in presenting this code during the First Five-Year Review. In 2011, Radiology represents a substantially smaller percentage of the claims, and the combination of all non-radiological specialties accounted for more than 67% of these services. The RUC agreed that there is compelling evidence that codes 93880 and 93882 are potentially misvalued.

***93880 Duplex scan of extracranial arteries; complete bilateral study***

The RUC reviewed the survey results from 61 radiologists, cardiologists and vascular surgeons and agreed that the median survey times accurately accounted for the physician work involved in the service: 5 minutes of pre-service time, 12 minutes of intra-service time and 5 minutes of post-service time.

The RUC reviewed the survey respondents' estimated work value and agreed with the specialty societies that a work RVU of 0.80, the survey median, is appropriate for CPT code 93880. To justify this value, the RUC reviewed the key reference service and MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81) and agreed that both codes have analogous physician work and intra-service time, 12 minutes for 93880 and 10 minutes for 76700, and should thus be valued similarly. The RUC also compared the surveyed code to CPT code 76776 *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* (work RVU= 0.76) and noted that both codes have similar physician work and intensity, however 93880 has 2 more minutes of intra-service time and should be valued slightly higher than the reference code. Finally, the RUC reviewed MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97) and agreed that with 5 additional minutes of intra-service time compared to 93880, the reference should be valued higher. **The RUC recommends a work RVU of 0.80 for CPT code 93880.**

***93882 Duplex scan of extracranial arteries; unilateral or limited study***

The RUC reviewed the survey results from 59 radiologists, cardiologists and vascular surgeons and agreed that the median survey times accurately accounted for the physician work involved in the service: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time.

The RUC reviewed the survey respondents' estimated work value and agreed with the specialty societies that a work RVU of 0.50, the survey median, is appropriate for CPT code 93882. To justify this value, the RUC reviewed the key reference service CPT code 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* (work RVU= 0.45) and agreed that both codes have identical intra-service time, 10 minutes, with analogous physician work. Therefore, the recommended work value of 0.50 accurately values 93882 in comparison to this reference code. Additionally, the RUC compared the surveyed code to MPC code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU= 0.56) and agreed that both services have identical intra-service time of 10 minutes and should be valued similarly. Finally, the RUC reviewed CPT code 92250 *Fundus photography with interpretation and report* (work RVU= 0.44) and noted that this reference code should be valued slightly lower than 93882 because it has less intra-service time and total time, 14 minutes compared to 20 minutes. **The RUC recommends a work RVU of 0.50 for CPT code 93882.**

**Practice Expense:**

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

**Electroencephalogram (Tab 22)**

**Marianna Spanaki, MD, PhD, (AAN); Marc Nuwer, MD, PhD, (ACNS)**

In the NPRM for 2012, CMS identified CPT code 95819 *Electroencephalogram (EEG); including recording awake and asleep* through the CMS High Expenditure Procedural Codes screen. The RUC added CPT codes 95816 *Electroencephalogram (EEG); including recording awake and drowsy* and 95822 *Electroencephalogram (EEG); recording in coma or sleep only* as part of this family.

**95816 Electroencephalogram (EEG); including recording awake and drowsy**

The RUC reviewed the survey results from 44 neurologists for CPT code 95816. The respondents indicated a median work RVU of 1.09, which is almost the same as the current work RVU of 1.08. The specialty societies did not believe there was compelling evidence that the work has changed. Therefore, the RUC recommended maintaining the current work RVU of 1.08 for CPT code 95816. The RUC agreed that the surveyed physician time of 5 minutes pre-, 15 minutes intra- and 6 minutes immediate post-service time appropriately account for the time required to perform this procedure. The RUC compared the surveyed code to the key reference service 95812 *Electroencephalogram (EEG) extended monitoring; 41-60 minutes* (work RVU = 1.08 and 20 minutes intra-service time) and noted that the respondents indicated the intensity and complexity required to perform these services is comparable. The RUC determined that the physician work required to perform 95812 and 95816 is the same. For further support, the RUC referenced CPT code 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU = 1.10 and 15 minutes intra-service time), which requires similar physician work and time. **The RUC recommends a work RVU of 1.08 for CPT code 95816.**

**95819 Electroencephalogram (EEG); including recording awake and asleep**

The RUC reviewed the survey results from 38 neurologists for CPT code 95819. The survey 25<sup>th</sup> percentile work RVU was 1.08, which is the current work RVU. The specialty societies did not believe there was compelling evidence that the work has changed. Therefore, the RUC recommended maintaining the current work RVU of 1.08 for CPT code 95819. The RUC agreed that the surveyed physician time of 5 minutes pre-, 15 minutes intra- and 6 minutes immediate post-service time appropriately account for the time required to perform this procedure. The RUC compared the surveyed code to the key reference service 95812 *Electroencephalogram (EEG) extended monitoring; 41-60 minutes* (work RVU = 1.08 and 20 minutes intra-service time) and noted that the respondents indicated the intensity and complexity required to perform these services is comparable. The RUC determined that the physician work required to perform 95812, 95816 and 95819 is the same. For further support, the RUC referenced CPT code 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU = 1.10 and 15 minutes intra-service time), which requires similar physician work and time. **The RUC recommends a work RVU of 1.08 for CPT code 95819.**

**95822 Electroencephalogram (EEG); recording in coma or sleep only**

The RUC reviewed the survey results from 36 neurologists for CPT code 95822 and agreed that while the survey respondents indicated a higher work RVU than the current value, the specialty societies did not believe there was compelling evidence that the work



has changed. Therefore, the RUC recommended maintaining the current work RVU of 1.08 for CPT code 95822. The RUC agreed that the surveyed physician time of 5 minutes pre-, 18 minutes intra- and 10 minutes immediate post-service time appropriately account for the time required to perform this procedure. The RUC agreed that there is 4 additional minutes of post-service in 95822 compared to 95819 due to the patient's comatose state, there is direct communication with the physician who referred the case for the EEG study. The RUC compared the surveyed code to the key reference service 95812 *Electroencephalogram (EEG) extended monitoring; 41-60 minutes* (work RVU = 1.08 and 20 minutes intra-service time) and noted that the respondents indicated the intensity and complexity required to perform these services is comparable. The RUC determined that the physician work required to perform 95812, 95816, 95819 and 95822 is the same. For further support, the RUC referenced CPT code 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU = 1.10 and 15 minutes intra-service time), which requires similar physician work and time. **The RUC recommends a work RVU of 1.08 for CPT code 95822.**

### **Practice Expense**

The RUC reviewed the direct practice expense inputs and noted that the minutes for equipment item *EEG, digital, testing system (computer hardware, software & camera)* (EQ330) are 9 minutes above the clinical staff time for the service period in all three of the codes. This is accounted for in the post-service period when the clinical staff uses the equipment to *prepare technician report in EEG file (3 minutes)*, *enter patient information into laboratory log book (2 minutes)* and *transfer data to reading station & archive data (4 minutes)*. The RUC accepted the direct practice expense inputs as submitted by the specialty societies and recommended by the Practice Expense Subcommittee.

### **Radiation Treatment Delivery – PE Only (Tab 23)**

**Najeeb Mohideen, MD (ASTRO); Ezequiel Silva, MD (ACR)**

In the July 30, 2012, Proposed Rule for 2013, 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.

The RUC discussed in detail the need for two radiation therapists (RT) to safely perform the service. The RUC strongly agrees with the specialty societies that there are clear guidelines requiring two RTs to meet the current standard of care, and agrees with the specialty that both RTs are doing concurrent, but distinct clinical activities critical in performing the service.

The specialty society provided the following table outlining each therapist's tasks, Two symbols (♣♣) indicate that the therapists are performing the task as a team and one symbol (♣) indicates that the therapist is performing the task independently.

| <b>Therapist #1</b>  | <b>Therapist #2</b>  |
|--|--|
| Greet patient, provide gowning, ensure appropriate medical records are available   | Prepare room, equipment, supplies  |
| Prepare and position   | Prepare and position   |
| Set up computer-controlled component of linear accelerator (linac) operation, working outside room at console<br><i>(Open electronic medical record and electronic prescription of patient to be treated, review prescription parameters, Open Record and Verify)</i>  | Set up mechanical component of linac operation, working inside room<br><i>(Operate manual control to verify functionality and move gantry, table and collimators to starting position)</i>   |
| <b>Perform Procedure (Therapist #1)</b><br><ul style="list-style-type: none"> <li>❖❖ Attach immobilization devices</li> <li>❖❖ Verify vertical/horizontal patient position around site to be treated</li> <li>❖❖ Use orthogonal 3-point laser light system to align patient w/external tattoos</li> <li>❖❖ Verify Isocenter</li> <li>❖ Verify proper performance of 2 audio/video motoring systems</li> <li>❖ Maintain Visual surveillance of gantry motion to verify no collision with table or patient and continuous audio-visual surveillance to verify patient comfort and positional stability during therapy</li> <li>❖ Repeat prior step for remaining 6 beams</li> <li>❖❖ Set gantry to safe position allowing patient to arise from table and assist patient up from treatment table and out of immobilization device</li> </ul> | <b>Perform Procedure (Therapist #2)</b><br><ul style="list-style-type: none"> <li>❖❖ Attach immobilization devices</li> <li>❖❖ Verify vertical/horizontal patient position around site to be treated</li> <li>❖❖ Use orthogonal 3-point laser light system to align patient w/external tattoos</li> <li>❖❖ Verify Isocenter</li> <li>❖ Verify proper performance of two audio/video monitoring systems</li> <li>❖ Set control to rotate the gantry angle of first beam for treatment, initiate treatment and continuous visual surveillance of computer monitor showing desired pattern of MLC motion during beam on time</li> <li>❖ Repeat prior step for remaining 6 beams</li> <li>❖❖ Set gantry to safe position allowing patient to arise from table and assist patient up from treatment table and out of immobilization device</li> </ul> |
| Clean Room   | Other Clinical Activity (please specify):<br>Document treatment administered in record and verify system   |

- ❖❖ Two therapists performing task with each other
- ❖ Single therapist task

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

In October 2012, the RUC's Practice Expense Subcommittee met and discussed the CMS request. The PE Subcommittee discussed the procedure time and number of staff related to 77418. The Subcommittee also verified that in October 2010 they agreed with the specialty society that two radiation therapists are required to perform this procedure. 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 77418 the specialty society should conduct a survey for clinical staff time. **The RUC recommends two radiation therapists for CPT code 77418. To verify the clinical staff time the RUC recommends that the specialty societies submit questions related to clinical staff time at all practice settings (total time for each clinical staff, percentage of time available for multitasking) to the Research Subcommittee for approval in order to be used in a survey specific to staff**

**time in IMRT services. In addition to the survey data the RUC recommends that the specialty societies submit representative daily schedules per treatment room from all practice settings for practice expense review in January 2013.**

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

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. 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 the specialty society should conduct a survey for clinical staff time. **To verify the clinical staff time the RUC recommends that the specialty societies submit questions related to clinical staff time at all practice settings (total time for each clinical staff, percentage of time available for multitasking) to the Research Subcommittee for approval in order to be used in a survey specific to staff time in SBRT services. In addition to the survey data the RUC recommends that the specialty societies submit representative daily schedules per treatment room from all practice settings, for practice expense review in January 2013.**

**XI. Practice Expense Subcommittee (Tab 24)**

Doctor Scott Manaker, Chair, provided a summary of the Practice Expense Subcommittee report. The Subcommittee reviewed the work of the Migration from Film to Digital Workgroup. The Workgroup has identified 605 CPT codes appropriate to be migrated from film to PACS, and most of the supplies and equipment. They are not working on clinical staff time issues and they plan to complete their recommendations by the April 2013 meeting so that they can be incorporated into the 2014 fee schedule.

The Pre-Service Time for 000 Day Globals in the Facility Workgroup identified 48 000 day global codes that had more than the 30 minutes standard for pre-service time. There were 3 levels developed, set at 0, 15 and 30 minutes depending on the amount of work for the clinical staff. The Workgroup identified the 48 codes that exceeded 30 minutes and requested comment from the specialty societies. You have received list of the 48 codes and the reductions in pre-service clinical staff time in accord with the standards. **The RUC recommends modifications to pre-service time for the 48 codes identified by the Workgroup as submitted by the PE Subcommittee.**

The radiation therapy codes for IMRT and SBRT were reviewed by the PE Subcommittee and significant questions were raised about the number of clinical staff, duration of beam time and duration of equipment use. The PE Subcommittee recommends to the RUC that the specialties submit questions related to clinical staff time (number of staff, total time for each clinical staff, and percentage of time available for multitasking) to the Research Subcommittee for approval in order to be used in a re-survey for practice expense. The Subcommittee also suggested that providing HIPPA compliant, representative schedules from one or more practices or institutions.

The Subcommittee recommends to the RUC that the following issues to be referred to the Research Subcommittee:

1. Following approval of the draft questions related to clinical staff time for radiation therapy codes the Research Subcommittee should consider similar questions to be included in the RUC survey instrument (see III, IMRT above).
2. Formal process based on RUC standards to require compelling evidence for increases to practice expense.
3. Provide 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 Subcommittee also discussed the following issue to be taken into consideration by a workgroup of the PE Subcommittee:

1. Standardize additional inputs for contrast imaging studies.

**The RUC approved the Practice Expense Subcommittee report.**

## **XII. HCPAC Review Board (Tab 25)**

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

### **Chiropractic Manipulative Treatment (98940-94943)**

CMS identified the Chiropractic Manipulative Treatment (CMT) codes as part of the CMS High Expenditure Procedures screen. The HCPAC noted that these services are currently crosswalked to the Osteopathic Manipulative Treatment (OMT) codes and those services were recently reviewed and work RVUs increased in February 2011.

The HCPAC agreed with the American Chiropractic Association that there was compelling evidence that the CMT codes were also inherently based on flawed methodology. The HCPAC questioned whether the work provided for OMT is different or more intense than CMT. The chiropractors indicated that the intra-service work is the same, the only difference is the PART requirements. PART is a collection of objective findings used to demonstrate the presence or absence of a subluxation using established physical examination procedures. **The HCPAC determined that since the survey time data is the same as current time and there is no difference in work and intensity when compared to the current OMT codes and the CMT codes should be crosswalked to the OMT codes.**

**The RUC approved the HCPAC Review Board report.**

## **XIII. Research Subcommittee (Tab 26)**

Doctor Scott Collins, Chair, provided a summary of the Research Subcommittee report. **The Research Subcommittee report from the June 2012 Conference Call is included in Tab 26 of the October 2012 agenda materials and was reviewed and approved by the RUC. The Mandated Services report from the August 2012 Conference Call is included in Tab 26 of the October 2012 agenda materials and was reviewed and approved by the RUC.**

The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) submitted a request to refine the survey process for EGD procedures which will be surveyed for the January 2013 RUC meeting. The specialty societies intend to use the standard survey instrument for the primary code(s) and a mini-survey to determine intra-service time for each other code within the family. The Research Subcommittee recommends that the societies identify the primary code(s) as well as all other codes within this family and present a more detailed plan during the Research Subcommittee conference call which will be scheduled in November 2012.

The American College of Radiology submitted a request to crosswalk some high volume ultrasound codes. The Subcommittee members agreed that a crosswalk may be inappropriate for these high volume codes which also include high intra service time. The Research Subcommittee recommends that the specialty society explore other survey options and present a plan at the January 2013 RUC meeting.

The Subcommittee expects an increase in work volume due to specialty societies requesting material to be reviewed and special projects. The Subcommittee members considered assignment of issues to members as well as initiating an advanced review process. The Research Subcommittee will continue to review and refine the process.

**The RUC approved the Research Subcommittee report.**

**XIV. Relativity Assessment Workgroup (Tab 27)**

**Outstanding Referrals to CPT Editorial Panel**

Doctor Raphaelson indicated that all outstanding referrals to the CPT Editorial Panel are in process. The Workgroup removed five codes (codes 36215, 36216, 36217, 75962 and 75964) from referral because the issues have addressed. The Workgroup will monitor all referrals until the process is completed.

**Joint CPT/RUC Workgroup on Codes Reported Together Update**

Doctor Raphaelson indicated that Doctor Zwolak provided the Workgroup with an update on the Codes Reported Together efforts. The RAW accepted the report with one minor change. The Joint Workgroup recommended that CPT code 77295 and 77300 be part of a bundling coding proposal. ASTRO indicated that there is not duplication of services. Additionally, ASTRO has submitted a CCP for upcoming October 2012 CPT meeting. **ASTRO recommended and the Relativity Assessment Workgroup agreed that the Joint Workgroup request to bundle 77295 with 77300 be removed.**

**Re-Review of Services to Consider Additional Utilization Data – Review Action Plans**

Doctor Raphaelson indicated that the next group of services was codes in which the RAW had previously reviewed but requested more data before requesting further action. The Workgroup reviewed 14 codes/9 families of services flagged to be re-reviewed after additional utilization data became available. The RAW recommended to remove some codes from review and requested two more years of data for other codes, to review later.

**The Workgroup recommended:**

| CPT Code | RAW Recommendation  |
|----------|---|
| 20926    | Remove from re-review, a category III code was created to report injection of |

|       |  |
|-------|--|
|       | platelet rich plasma and volume is dropping.   |
| 22851 | Review after 2 more years of data. There was a CPT editorial change in 2011 to remove the threaded bone from 22851 and the changes may not be apparent in the 2011 preliminary data available. |
| 26080 | Review after 2 more years of data (may need to review site of service issues if not addressed).  |
| 36245 | Survey Feb 2013 (also identified on CMS Harvard >\$10 mil allowed charges).  |
| 36246 | Remove from re-review (recently RUC reviewed Feb 2011).  |
| 36247 | Remove from re-review (recently RUC reviewed Feb 2011).  |
| 36516 | Remove from re-review as volume is low.  |
| 63056 | Review after 2 more years of data. There was a 2012 introductory language change to correct appropriate reporting of 62287 instead of 63056.   |
| 64415 | Review after 2 more years of additional data. CPT Assistant article published Dec 2011 and April 2012.   |
| 64445 | Review after 2 more years of additional data. CPT Assistant article published Dec 2011 and April 2012.   |
| 64447 | Review after 2 more years of additional data. CPT Assistant article published Dec 2011 and April 2012.   |
| 77001 | Remove from re-review, this service is an add-on code.   |
| 77002 | Review in September 2016 after the October 2012 coding proposal to clarify coding guidelines is created and subsequent data may be reviewed.   |
| 93976 | Remove from re-review, growth is less than 10% per year and slowing, also below CMS/Other screen utilization criteria of 500,000.  |

#### **New Technology/New Services List – Review Action Plans**

The Workgroup reviewed 126 codes or 13 families of services of services that were flagged as new technology. The soft tissue tumor codes and cardiac device monitoring codes were actually not considered new technology, but were originally placed on this list as part of a way to flag for re-review. The Workgroup recommended removal of codes from this list of the volume was low and specific utilization assumptions were correct.

#### **The Workgroup recommended:**

| <b>CPT Code</b> | <b>RAW Recommendation</b>  |
|-----------------|--|
| 20696           | Remove from list, volume low and utilization assumptions appropriate.  |
| 20697           | Remove from list, volume low and utilization assumptions appropriate.  |
| 22856           | Remove from list, volume low and utilization assumptions appropriate.  |
| 22861           | Remove from list, volume low and utilization assumptions appropriate.  |
| 22864           | Remove from list, volume low and utilization assumptions appropriate.  |
| 43273           | Specialty to survey April 2013.  |
| 43279           | Remove from list, volume low and utilization assumptions appropriate.  |
| 55706           | Review after 2 more years of data, as volume is higher than predicted.   |
| 63620           | Remove from list, volume low and utilization assumptions appropriate.  |
| 63621           | Remove from list, volume low and utilization assumptions appropriate.  |
| 65756           | Remove from list. Though volume grew faster than expected, there was a decrease in other services of similar magnitude that were previously reported and had similar work RVUs. All remained work neutral. |
| 65757           | Remove from list   |
| 95803           | Remove from list, volume low and utilization assumptions appropriate.  |

**Soft Tissue Tumor Excision Codes (work neutrality review):**

The Workgroup reviewed the soft tissue tumor excision codes and recommended:

- **To remove the bone tumor codes from the list** as the original recommendation were not assumed to be work neutral and utilization is low as predicted.
- **To review the new excision codes in 3 years after CPT changes are in effect and additional utilization data is available** (this family original recommendations were not assumed to be work neutral).
- **To review the radical excision codes in 3 years after CPT introductory language changes are in effect, reporting education has occurred and additional utilization data is available** (this family original recommendations were not assumed to be work neutral).
- **To review the subfascial excision codes in 3 years after additional data is available** (this family original recommendations were not assumed to be work neutral). Site-of-service anomalies exist for 5 codes with utilization over 1,000. The RAW recognized that its policy that there must be 3 consecutive years of data indicating 50% or less inpatient per year in order to eliminate any annual fluctuations in the claims data.
- **To review the subcutaneous excision codes in 3 years after additional data is available.** Recommendations were assumed to be work neutral after 2.88% reduction applied to entire soft tissue tumor excision codes to maintain neutrality and rank order for this family of services. The increase in work RVUs is 2.0%. The specialties are submitting CPT Assistant and CCPs to correct any miscoding of these services. The specialties coding changes would go into effect in 2014, and to gather at least one year of data to determine the actual percentage of increase the next RAW review would be in Oct 2015.

**Cardiac Device Monitoring (work neutrality review):**

The original recommendations for the cardiac device monitoring codes were assumed to be work neutral. The Workgroup reviewed the utilization assumptions for these services which appear to have a 22% increase total work RVUs compared to the originally assumed. That appears to be due to explicable clinical criteria such as patients living longer and changes in practice parameters. **Therefore, the Workgroup recommended that an Ad Hoc Workgroup be formed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.**

**NPRM for 2013 Specific Requests – Review Action Plans**

CMS identified potentially misvalued services, Harvard-valued codes with annual allowed charges greater than \$10 million and practice expense services with stand-alone procedure time for the RUC to review. The Relativity Assessment Workgroup requested action plans from specialty societies on how to address these services. **The Workgroup recommendations for each of these services are as follows:**

**Potentially Misvalued Services:**

| <b>CPT Code</b> | <b>RAW Recommendation</b>  |
|-----------------|--|
| 33282<br>33284  | Remove from screen, not performed in the office setting (0.64%). |
| 63650           | Review PE by April 2013 meeting.                                 |
| 77336           | Review PE by April 2013 meeting.                                 |

**Table 7: Harvard-Valued Codes with Annual Allowed Charges >\$10 million**

| <b>CPT Code</b> | <b>RAW Recommendation</b>  | <b>Code Family</b>                       |
|-----------------|--|--|
| 13152           | <i>Complete RUC recommendation submitted for CPT 2013</i>  |  |
| 27446           | Survey Feb 2013  |  |
| 29823           | Survey April 2013  |  |
| 36215<br>36245  | 36215 - Utilization expected to change after the revisions to the cervicocerbral angiography codes approved by the RUC in April 2012. Review after 3 years of additional data and after coding structure change has taken effect. 36245-Survey Feb 2013. |  |
| 43264           | Survey April 2013  |  |
| 50360           | Survey Feb 2013  |  |
| 52353           | <i>Complete. RUC recommendation submitted for CPT 2013</i>   |  |
| 64450           | <i>Complete. RUC recommendation submitted for CPT 2013</i>   |  |
| 64590           | Remove from screen. Allowed charges are ~\$1 million   | 64595                                    |
| 66180           | Survey Feb 2013  | 66185                                    |
| 67036           | Survey Oct 2013  | 67039-67043                              |
| 67917           | Survey April 2013  | 67914, 67915 67916, 67917, 67921, 67922, |



|       |  |                  |
|-------|--|------------------|
|       |  | 67923, and 67924 |
| 92286 | <i>Complete. RUC recommendation submitted for CPT 2013</i> |                  |
| 92982 | <i>Deleted from CPT 2013.</i>                              |                  |
| 95860 | <i>Complete. RUC recommendation submitted for CPT 2013</i> |                  |

A RUC member questioned why CPT code 50360 *Renal allotransplantation, implantation of graft; without recipient nephrectomy* was on the list for re-review. Doctor Raphaelson indicated that the CMS identified this code through the Harvard-Valued screen and the Workgroup reviewed and determined that this service does indeed need to be surveyed.

**Table 9: PE Services with Stand-Alone Procedure Time**

These services were identified by CMS via the Services with Stand Alone PE Procedure Time screen. CMS is proposing to review and make adjustments to CPT codes with stand alone procedure time assumptions used in developing non-facility PE RVUs. These procedure time assumptions are not based on physician time assumptions. CMS is prioritizing for review CPT codes that have annual Medicare allowed charges of \$100,000 or more include direct equipment inputs that amount to \$100 or more, and have PE procedure times of greater than 5 minutes. **The Workgroup recommends:**

| <b>CPT Code</b>  | <b>RAW Recommendation</b>   |
|--|---|
| 77280<br>77285<br>77290  | CCP submitted for CPT Oct 2012 meeting. RUC review Feb 2013.  |
| 77301  | <i>Complete. RUC submitted recommendations for CPT 2013.</i>  |
| 77338  | Evaluated at RUC in February 2009. Review PE data at the Feb 2013 RAW meeting as provided by ASTRO. |
| 77372<br>77373   | 77372 - Review PE by April 2013<br>77373 - Reviewed at this meeting, Oct 2012                       |
| 77402<br>77403<br>77404<br>77406<br>77407<br>77408<br>77409<br>77411<br>77412<br>77413<br>77414<br>77416<br>77417<br>77418 | 77402-77417 - Review PE by April 2013<br>77418 - Reviewed at this meeting, Oct 2012                 |
| 77600  | Do not review. RUC reviewed in 2004, TC utilization is 4 for 2011. Too low to review at this time.  |
| 77785<br>77786   | Do not review at this time. Recently RUC reviewed in Oct 2009.                                      |

|                |   |
|----------------|---|
| 77787          |   |
| 88348<br>88349 | Review PE at Oct 2013 RUC meeting. CPT code 88349 added as part of this family. |

**The Workgroup requests that the Research Subcommittee review alternate methods for determination of stand-alone practice expense. Until an alternate method is accepted, further review of stand-alone time recently evaluated, is not likely to be productive.**

**Other Issues**

A Workgroup member questioned if previous screens have been run again based on new data. AMA staff indicated that they will update the screens and present data at a future meeting for the Workgroup planning process.

**The RUC approved the Relativity Assessment Workgroup report.**

**XV. Other Issues**

There was a referral to the Research Subcommittee to consider adding a length of stay question to the RUC survey.

**Doctor Levy adjourned the meeting at 2:59 pm on Saturday, October 6, 2012.**