

**AMA/Specialty RVS Update Committee
Meeting Minutes
October 3-5, 2013**

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, October 4, 2013 at 8:09 am.
The following RUC Members were in attendance:

Barbara Levy, MD	James C. Waldorf, MD
Margie C. Andreae, MD	George Williams, MD
Michael D. Bishop, MD	Amr Abouleish, MD, MBA*
James Blankenship, MD	Allan A. Anderson, MD*
Dale Blasier, MD	Gregory L. Barkley, MD*
Albert Bothe, MD	Gregory DeMeo, MD*
Ronald Burd, MD	Jane Dillon, MD*
Scott Collins, MD	Verdi DiSesa, MD*
Thomas Cooper, MD	William D. Donovan, MD, MPH, FACR*
Anthony Hamm, DC	Jeffrey Paul Edelstein, MD*
David F. Hitzeman, DO	Yul Ejnes, MD*
Charles F. Koopmann, Jr., MD	William E. Fox, MD, FACP*
Walt Larimore, MD	William F. Gee, MD*
Alan Lazaroff, MD	Mollie MacCormack*
M. Douglas Leahy, MD, MACP	Daniel McQuillen, MD*
J. Leonard Lichtenfeld, MD	Terry L. Mills, MD*
Scott Manaker, MD, PhD	Eileen Moynihan, MD*
William J. Mangold, Jr., MD	Margaret Neal, MD*
Larry Martinelli, MD	Scott D. Oates, MD*
Geraldine B. McGinty, MD	Christopher K. Senkowski, MD, FACS*
Gregory Przybylski, MD	M. Eugene Sherman, MD*
Marc Raphaelson, MD	Samuel Silver, MD*
Sandra Reed, MD	Holly Stanley, MD*
David Regan, MD	Robert J. Stomel, DO*
Chad A. Rubin, MD, FACS	G. Edward Vates, MD*
Peter Smith, MD	Jane White, PhD, RD, FADA, LDN*
Samuel D. Smith, MD	Jennifer L. Wiler, MD*
Stanley W. Stead, MD, MBA	
J. Allan Tucker, MD	*Alternate

II. Chair's Report

- Doctor Levy welcomed everyone to the RUC Meeting.
- Center for Medicare & Medicaid Services (CMS) staff and representatives were unable to attend the meeting because of the government shutdown.
- Doctor Levy welcomed the following Contractor Medical Director:
 - Charles Haley, MD, MS, FACP
- Kevin Hayes from MedPAC was scheduled to attend, but was unable to travel due to government shutdown.
- Doctor Levy welcomed the following observer:

- David Chan, PhD, MD, MSc, Assistant Professor, Center for Health Policy/Center for Primary Care and Outcomes Research at Stanford University School of Medicine
- Doctor Levy welcomed the following new RUC members
 - Margie Andreae, MD – American Academy of Pediatrics
 - Samuel Smith, MD – American Pediatric Surgical Association
 - Thomas Cooper, MD – American Urological Association
 - David Regan, MD – American Society of Clinical Oncology
 - Stan Stead, MD – American Society of Anesthesiologists
- Doctor Levy welcomed the following new alternate RUC members:
 - Mollie MacCormack, MD – American Academy of Dermatology
 - Eileen Brewer, MD – American Academy of Pediatrics
 - Amr Abouleish, MD – American Society of Anesthesiologists
 - Samuel Silver, MD - American Society of Clinical Oncology
- On August 28, 2013 Doctors Levy, Smith and Hollmann met with John Blum, Deputy Administrator at the Center for Medicare & Medicaid Services (CMS) and other CMS staff to discuss Chronic Care Coordination Workgroup (C3W) efforts and the Proposed Rule.
 - Doctor Peter Smith provided a report on the meeting, explaining that the representatives from CPT and the RUC discussed the difference in the types of patients that would be eligible for the services when providing 60 minutes of care within 30 days versus 60 minutes of care within 90 days. It is important to confine these codes to very acute patients to start, so that data can be collected and value can be demonstrated. Originally the codes were not funded and an initial and subsequent visit was the proposed structure. CMS plans to implement with CPT codes rather than G codes in January 2015. The Workgroup is submitting a draft CPT proposal, for two codes, one for an initial visit with 60 minutes of care coordination within 30 days and the other for an add-on code for additional care. This is an editorial change. The group also articulated to CMS that there should be a mechanism to provide these services without going through the expensive process of becoming NCQA qualified.
- Doctor Levy laid out the following guidelines related to RUC proceedings:
 - There is a confidentiality policy that needs to be signed at the registration table for all RUC members and alternates.
 - Proceedings are recorded in order for RUC staff to create the meeting minutes.
 - RUC members must state if they have a conflict of interest before a presentation. 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.
 - RUC members should state their conflict of interest, if applicable, and the member will not discuss or vote on the issue. This will be reflected in our minutes.
- Doctor Levy laid out the following guidelines related to voting:
 - The votes will be published as previously outlined by the Administrative Subcommittee, starting in November 2013 (representing the 2014 CPT cycle).
 - We are voting on every work RVU, including facilitation reports
 - Please share voting remotes with your alternate if you step away from the table
 - To ensure we have 28 votes, may necessitate re-voting throughout the meeting

- If members are going to abstain from voting or leave the table, please notify AMA staff so we may account for all 28 votes

III. Director's Report

- The AMA has engaged with a consultant to update the RUC database including making it Mac compatible and allowing downloading online through a password protected site. We will also be able to distribute the agenda through this password protected site. This should be available by January's meeting. Ruby will work with you between meetings to set up access.

IV. Approval of Minutes of the April 25-27, 2013 RUC Meeting

The RUC approved the April 2013 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

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

- The CPT Panel met in Chicago, IL in mid-May. Doctor Bishop attended the meeting as the RUC representative.
- The Panel reviewed 35 code proposals and 12 administrative issues.
- As a maintenance measure, the Panel reviews category III codes that are set to sunset. In May the panel reviewed 14 codes. These codes are not reviewed by the RUC, but it is an important part of the CPT tracking system. CPT routinely contacts the society that originally submitted the proposal to inquire if they wish to renew. Most were renewed to the year 2019.
- Also, as a maintenance measure, CPT developed a process to review procedures with utilization of 10 or less. We found 113 procedures that fit into this category, primarily from the 1990s or earlier and will be reviewing them at our meeting next week.
- Lastly, the Panel reviewed its Advisor Comment Form. The form was revised and enhanced.
- At the CPT meeting next week, we will be looking at 50 new proposals. In addition, it is the annual Panel and Advisors meeting and we will discuss a number of critical topics, including:
 - Medical home reporting
 - Molecular pathology coding and reporting
 - Other issues of code maintenance

VI. Contractor Medical Director Update (Informational)

Doctor Charles Haley, CMD, provided the contractor medical director update:

- Currently the government is shut down and CMS is being staffed by a couple dozen people; however, the Contractor Medical Directors are processing claims and there are no interruptions in payments.
- Two contractor changes: jurisdictions 6: Minnesota, Wisconsin and Illinois transitioned this summer and the new contractor is national government services (NGS); jurisdiction E: Nevada, California, Hawaii and the trust territory of the Pacific transitioned this summer and the new contractor is Noridian.

- CMS has published a new inpatient rule. This is a very important and beneficial rewrite in the rules and will assist in reducing payment error rate. Medicare has the highest payment error rate of any government program and most are related to inappropriate classification of an inpatient stay. Two important aspects of the new rules are:
 - There must be a hospital order admitting the patient by a physician.
 - Patient should be admitted as an inpatient if they will be there for a 24 hour period that includes two midnights. If only one midnight, patient should be kept as an outpatient in observation.
- Nine contractors are coordinating their activities – coordinating their local policy making and review efforts, etc.
 - The most aggressive effort has been with Molecular Pathology codes. The contractors are now uniform about which diagnostics are covered and not covered. Extensive coordinated research on how these should be fairly priced.
 - Coordinating local policies on pain management and nerve conduction studies.
 - Coordinating local policies on qualitative or quantitative drug testing.
- Questions:
 - Can a Physician Assistant and/or Nurse Practitioner initiate an order to admit? Look at the instructions document on CMS website. Another issue is if residents can admit. CMS is considering and reviewing and will put clarification on website.
 - ACC stated a concern on payment reform and payment structure.

VII. Washington Update (Informational)

Richard Deem, Senior Vice President of Advocacy, AMA, provided the RUC with the following information regarding the AMA's advocacy efforts:

As you all know, we are in the midst of a Federal government shutdown. There are a number of factors that led to this point including many attempts at repeal of the Accountable Care Act (ACA), the 2011 debt ceiling and the 2012 fiscal cliff. During the shutdown the following programs will continue: payment of Medicare claims, CMMI activities, Medicaid, CHIP, ACA implementation, fraud & abuse enforcement, direct patient care at IHS and current patients at NIH, select FDA vital programs. The Federal debt ceiling extension deadline is October 17th, 2013. This affects the credit rating of the country and global financial markets. To reach a "grand bargain" would require revenue increase and entitlement reform, primarily structural reforms to Medicare.

Opportunities for SGR reform include a shift to new payment models and reduction in existing penalties & burdens. The cost of patches to the SGR continues to increase and is fiscally irresponsible, while repeal is fiscally responsible. The total cost of patches from 2003-2013 is \$146.4 billion and the cost of another patch for 2014 is 18.1 billion, totaling \$164.5 billion, while the price for repeal/10 year freeze is \$140 billion. The House Energy and Commerce Committee has produced a package, and the House Ways and Means Committee is set to release a package in October. The Senate Finance Committee is also supposed to produce a product in October. The AMA encourages everyone to get involved with our grassroots advocacy efforts to repeal the SGR.

The ACA is being implemented this month. The AMA has put together materials for physicians and patients on the enrollment process. Under a final CMS rule, patients have a three-month grace period for a premium payment delinquency; insurers are responsible for covering services during the first 30 days of the grace period, but physicians may be

responsible for trying to collect from the patient for services provided during days 31-60, if the patient is terminated from the plan. The AMA continues to address this issue with senior CMS staff and we are working to get a resolution before Jan. 1.

VIII. Relative Value Recommendations for CPT 2015:

Ileoscopy (Tab 4)

Joel Brill, MD (AGA); Shivan Mehta, MD (AGA); Nicholas Nickl, MD (ASGE); Edward Bentley, MD (ASGE); R. Bruce Cameron, MD (ACG)

Several specific codes identified by CMS through the MPC List screen were scheduled for review at the September 2011 RUC meeting. The RUC review of the codes led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The specialty societies representing gastroenterology indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to clarify and update CPT code descriptions. The specialty societies worked with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services.

In the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. For the CPT 2015 cycle, the RUC reviewed the illeoscopy, pouchoscopy and flexible sigmoidoscopy services in October 2013 and will review colonoscopy and colonoscopy through the stoma procedures in January 2014. Given that this process will require the RUC and specialty societies to survey and review the entire family of endoscopy procedures, the RUC has consistently maintained that relativity within both the immediate and larger family is of paramount importance. As was done in the previous set of codes, the RUC used an incremental methodology to value the additional physician work above the base diagnostic procedure. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed, relativity amongst the family is critical. The potential for rank order anomalies is high considering the large number of codes reviewed in succession. Second, CMS (then HCFA) used the incremental approach in their initial valuation of these services in 1992 and 1993. According to CMS commentary in the Federal Register for those years, the agency established a hierarchy of work from the least to the most difficult endoscopic procedure. Following this, fixed increments were added to the base procedure. Therefore, the RUC determined that these new codes should continue to be valued the same way endoscopic services were initially valued at the creation of the RBRVS. Finally, the RUC has established valuation of physician work through incremental intra-service work as an approved, viable alternate methodology. In fact, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

44380 Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed

The RUC reviewed the survey results of 76 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time of 25 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.

The RUC reviewed the estimated work values and agreed with the specialty societies that 44380 is currently overvalued, with a work RVU of 1.05. However, the survey respondents overestimated the physician work involved in this service at the 25th percentile. Therefore, the RUC reviewed CPT code 91040 *Esophageal balloon distension provocation study* (work RVU= 0.97) and noted that both services have identical intra-service time of 15 minutes and similar total time, 45 minutes and 50 minutes, respectively. The RUC agreed with the specialty societies that code 44380 should be value at 0.97 work RVUs, identical to the reference code.

To justify a work RVU of 0.97, the RUC compared the surveyed code to CPT code 49460 *Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation and report* (work RVU= 0.96) and agreed that with identical intra-service time, 15 minutes, both codes should be valued nearly identical. The RUC also reviewed MPC code 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* (work RVU= 0.81) and noted that this code has significantly less total time compared to 44380, 22 minutes and 50 minutes, respectively and is appropriately valued less than 44380. Finally, to ensure relativity within the endoscopic family, the RUC noted that the recommended RVU of 0.97 places diagnostic ileoscopy appropriately between diagnostic flexible sigmoidoscopy (RUC recommended work RVU= 0.84) and diagnostic esophagoscopy (RUC recommended work RVU= 1.59) in terms of comparative physician work. **The RUC recommends a work RVU of 0.97 for CPT code 44380.**

44382 Ileoscopy, through stoma; with biopsy, single or multiple

The RUC reviewed the survey results of 66 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 20 minutes and post-service time of 12 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient under sedation was appropriate.

The RUC reviewed the estimated work values and agreed with the specialties that the survey respondents overestimated the work value for this procedure. Therefore, consistent with the incremental methodology established by the RUC to value the entire endoscopic family of services, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy biopsy code, 43202 (RUC recommended work RVU= 1.89) should be maintained for this ileoscopy biopsy code. The established increment for the physician work related to the biopsy, 0.30 work RVUs, was added to the base ileoscopy diagnostic code, 44380 (RUC recommended work RVU= 0.97), for a recommended work RVU of 1.27 for CPT code 44382. The RUC agreed with the specialty that the physician work related solely to biopsy is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate. The RUC also noted that applying this methodology derives the current work RVU of 1.27 for this service.

To justify a work RVU of 1.27, the RUC compared the surveyed code to CPT codes 36597 *Repositioning of previously placed central venous catheter under fluoroscopic guidance* (work RVU= 1.21) and 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report* (work

RVU= 1.28) and noted that these comparator codes have identical intra-service times compared to 44382, 20 minutes and comparable physician work. Given these similarities, the RUC agreed that a recommended work value of 1.27 appropriately sets 44382 relative to these two reference codes. The RUC also reviewed MPC code 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU= 1.22) and noted that while the reference code has 5 minutes less intra-service time compared to the surveyed code, the reference code is a more intense service and should be valued similarly. Finally, to ensure relativity within the endoscopic family, the RUC noted that the recommended RVU of 1.27 places ileoscopy with biopsy appropriately between flexible sigmoidoscopy with biopsy (45331, RUC recommended work RVU= 1.14) and esophagoscopy with biopsy (43202, RUC recommended work RVU= 1.89) in terms of comparative physician work. **The RUC recommends a work RVU of 1.27 for CPT code 44382.**

4438X1 Ileoscopy, through stoma; with transendoscopic balloon dilation

The RUC reviewed the survey results of 48 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time of 32 minutes, intra-service time of 25 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient, straight forward procedure under sedation was appropriate. The RUC agreed that this is a difficult patient because the reason for dilatation is that the patient has an intermittent small bowel obstruction typically resulting from a neoplasm, ischemia or Crohn's disease.

The RUC reviewed the estimated work values and agreed with the specialties that the survey respondents overestimated the work value for this procedure. Therefore, consistent with the incremental methodology established by the RUC to value the entire endoscopic family of services, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy balloon dilation code, 43220 (RUC recommended work RVU= 2.10) should be maintained for this ileoscopy dilation code. The established increment for the physician work related to the balloon dilation, 0.51 work RVUs, was added to the base ileoscopy diagnostic code, 44380 (RUC recommended work RVU= 0.97), for a recommended work RVU of 1.48 for CPT code 4438X1. The RUC agreed with the specialty that the physician work related solely to balloon dilation is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.48, the RUC compared the surveyed code to MPC code 90935 *Hemodialysis procedure with single evaluation by a physician or other qualified health care professional* (work RVU= 1.48) and noted that both services have identical intra-service time, 25 minutes, and should be valued identically. In addition, the RUC reviewed CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU= 1.56) and agreed that with identical intra-service time, this reference code should be valued similarly to code 4438X1. Finally, to ensure relativity within the endoscopic family, the RUC noted that the recommended RVU of 1.48 places ileoscopy with trans-endoscopic balloon dilation appropriately between flexible sigmoidoscopy (45340, RUC recommended work RVU= 1.35) and esophagoscopy with trans-endoscopic balloon dilation (43220, RUC recommended work RVU= 2.10) in terms of comparative physician work. **The RUC recommends a work RVU of 1.48 for CPT code 4438X1.**

4438X4 Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

The RUC reviewed the survey results of gastroenterologists and gastrointestinal and endoscopic surgeons and noted that the combined survey sample of 43 survey respondents indicated a median performance rate of zero. Therefore, the RUC reviewed the survey results from the 21 physicians who perform the service and agreed with the specialty societies that the median intra-service time of 40 minutes was an accurate estimate of the time to perform this service. Additionally, 15 minutes is warranted over the balloon dilation code, 4438X1, due to the additional work of performing the pre and post dilation and guide wire passage that is included in 4438X4. The RUC recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 40 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient, straight forward procedure under sedation was appropriate. The RUC agreed that this is a difficult patient because the reason for placement of a stent is that the patient has a narrowing or obstruction of the lumen of the bowel resulting from a neoplasm.

The RUC reviewed the estimated work values and agreed with the specialties that the survey respondents overestimated the work value for this procedure. Therefore, consistent with the incremental methodology established by the RUC to value the entire endoscopic family of services, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy stent placement code, 43212 (RUC recommended work RVU= 3.73) should be maintained for this ileoscopy stent placement code. The established increment for the physician work related to placing the stent, 2.14 work RVUs, was added to the base ileoscopy diagnostic code, 44380 (RUC recommended work RVU= 0.97), for a recommended work RVU of 3.11 for CPT code 4438X4. The RUC agreed with the specialty that the physician work related solely to placing the stent is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 3.11, the RUC compared the surveyed code to CPT codes 52310 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple* (work RVU= 2.81) and 49446 *Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 3.31) and agreed that since these code all have identical intra-service time, 40 minutes, and comparable physician work, the recommended RVU for 4438X4 is valued appropriately between these two reference codes. The RUC also reviewed MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80) and agreed that while both codes have identical intra-service times, the MPC code is appropriately valued higher than the surveyed code due to increased intensity. Finally, to ensure relativity within the endoscopic family, the RUC noted that the recommended RVU of 3.11 places ileoscopy with stent placement appropriately between flexible sigmoidoscopy (4534X7, RUC recommended work RVU= 2.98) and esophagoscopy with stent placement (43212, RUC recommended work RVU= 3.73) in terms of comparative physician work. **The RUC recommends a work RVU of 3.11 for CPT code 4438X4.**

Practice Expense:

The Practice Expense Subcommittee reviewed the direct practice expense inputs for the ileoscopy services and noted that these services mostly crosswalk from the esophagoscopy codes approved last year. The PE Subcommittee approved non-facility direct PE inputs for two codes (44380 and 44382) which were only priced in the facility. For the new codes, 4438X1 was crosswalked to 44382 and 4438X4 was only priced in the facility.

The RUC approved the revised PE spreadsheet as modified by the PE 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.

Do Not Use to Validate:

The specialties requested, and the RUC agreed, that this family of codes should have a note in the RUC database that states codes 44380, 44382, 4438X1 and 4438X4 should not be used to validate for physician work. The specialties stated that the IWPUTs for these services are artificially low in comparison to other endoscopic procedures.

Pouchoscopy (Tab 5)

Joel Brill, MD(AGA); Shivan Mehta, MD (AGA); Nicholas Nickl, MD (ASGE); Edward Bentley, MD (ASGE); R. Bruce Cameron, MD (ACG); Guy Orangio, MD (ASCRS); Christopher Senkowski, MD (ACS); Donald Selzer, MD (SAGES)

Several specific CPT codes identified by CMS through the MPC List screen were scheduled for review at the September 2011 RUC meeting. The RUC review of the codes led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The specialty societies representing gastroenterology indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to clarify and update CPT code descriptors. The specialty societies worked with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services.

In the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. For the CPT 2015 cycle, the RUC reviewed the ileoscopy, pouchoscopy and flexible sigmoidoscopy services in October 2013 and will review colonoscopy and colonoscopy through the stoma procedures in January 2014. Given that this process will require the RUC and specialty societies to survey and review the entire family of endoscopy procedures, the RUC has consistently maintained that relativity within both the immediate and larger family be of paramount importance. As was done in the previous set of codes, the RUC used an incremental methodology to value the additional physician work above the base diagnostic procedure. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed, relativity amongst the family is critical. The potential for rank order anomalies is high considering the large amount of codes reviewed in succession. Second, CMS (then HCFA) used the incremental approach in their initial valuation of these services in 1992 and 1993. According to CMS commentary in the Federal Register for those years, the agency established a hierarchy of work from the least to the most difficult endoscopic procedure. Following this, fixed increments were added to the base procedure. Therefore, the RUC determined that these new codes should continue to be

valued the same way endoscopic services were initially valued at the creation of the RBRVS. Finally, the RUC has established valuation of physician work through incremental intra-service work as an approved, viable alternate methodology. In fact, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

44385 Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed

The RUC reviewed the survey results of 63 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends 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 for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialty societies that 44385 is currently overvalued, with a work RVU of 1.82. Therefore, the RUC agreed that the survey's 25th percentile, 1.30 work RVUs, is an accurate value for this service. To justify a work RVU of 1.30, the RUC compared the surveyed code to MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina* (work RVU= 1.50). While both services have identical intra-service time, 15 minutes, the RUC agreed that 57452 is a more intense procedure and should be valued higher than 44385. In addition, the RUC reviewed CPT code 46611 *Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique* (work RVU= 1.30) and agreed that since this code and the surveyed code have identical intra-service times and nearly identical total times, 50 minutes and 52 minutes, respectively, the two codes should be valued identically. Finally, the RUC noted that the recommended work RVU of 1.30 maintains the appropriate rank order between this pouchoscopy diagnostic procedure and the ileoscopy and esophagoscopy diagnostic procedures. This also confirms pouchoscopy as a more intense and complex procedure than ileoscopy because of the number of anastomotic lines involved, retroflexion in the pouch that is specific to each individual's anatomy, and a higher risk of perforation due to less compliance of the pouch secondary to scarring and rotation to left or right pelvic wall. **The RUC recommends a work RVU of 1.30 for CPT code 44385.**

44386 Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple

The RUC reviewed the survey results of 63 gastroenterologists and several surgeon subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 17 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 for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialty societies that while the current work RVU of 2.12 is too high for 44386, the survey respondents underestimated the value at the 25th percentile, 1.50 work RVUs. Consistent with the

incremental methodology established by the RUC to value the entire endoscopic family of services, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy biopsy code, 43202 (RUC recommended work RVU= 1.89) should be maintained in this pouchoscopy biopsy code. Therefore, the established increment for the physician work related to the biopsy, 0.30 work RVUs, was added to the base pouchoscopy diagnostic code, 44385 (RUC recommended work RVU= 1.30), for a recommended work RVU of 1.60 for CPT code 44386. The RUC agreed with the specialty that the physician work related solely to biopsy is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.60, the RUC compared the surveyed code to CPT codes 64447 *Injection, anesthetic agent; femoral nerve, single* (work RVU= 1.50) and 15271 *Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area* (work RVU= 1.50) and noted that while noted that all three services have similar physician work, the reference codes should be valued slightly less due to less intra-service time than the surveyed code, 15 minutes compared to 17 minutes. Finally, the RUC reviewed MPC code 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU= 1.90) and noted that while the reference code has slightly less intra-service time, 15 minutes, compared to 44386, the reference code is a more intense procedure and is justly valued higher than the surveyed code. **The RUC recommends a work RVU of 1.60 for CPT code 44386.**

Practice Expense:

The Practice Expense Subcommittee reviewed the direct practice expense inputs for the pouchoscopy services and noted that these services mostly crosswalk from the esophagoscopy codes approved last year. For both codes, the total clinical labor slightly increased due to making several refinements approved by the RUC last year for the esophagoscopy codes. The supplies and equipment remained relatively stable, with changes results from the previous year's refinements. Finally the PE Subcommittee did approve one new equipment item specifically related to these types of procedures (videoscope, sigmoidoscopy). The RUC approved the revised PE spreadsheet as modified by the PE 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.

Flexible Sigmoidoscopy (Tab 6)

Joel Brill, MD(AGA); Shivan Mehta, MD (AGA); Nicholas Nickl, MD (ASGE); Edward Bentley, MD (ASGE); R. Bruce Cameron, MD (ACG); Guy Orangio, MD (ASCRS); Christopher Senkowski, MD (ACS); Donald Selzer, MD (SAGES)

Several specific CPT codes identified by CMS through the MPC List screen were scheduled for review at the September 2011 RUC meeting. The RUC review of the codes led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The specialty societies representing gastroenterology indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to clarify the coding and update the descriptors via the CPT

Editorial Panel Process. The specialty societies worked with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services.

In the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. For the CPT 2015 cycle, the RUC reviewed the illeoscopy, pouchoscopy and flexible sigmoidoscopy services in October 2013 and will review colonoscopy and colonoscopy through the stoma procedures in January 2014. Given that this process will require the RUC and specialty societies to survey and review the entire family of endoscopy procedures, the RUC has consistently maintained that relativity within both the immediate and larger family be of paramount importance. As was done in the previous set of codes, the RUC used an incremental methodology to value the additional physician work above the base diagnostic procedure. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed, relativity amongst the family is critical. The potential for rank order anomalies is high considering the large amount of codes reviewed in succession. Second, CMS (then HCFA) used the incremental approach in their initial valuation of these services in 1992 and 1993. According to CMS commentary in the Federal Register for those years, the agency established a hierarchy of work from the least to the most difficult endoscopic procedure. Following this, fixed increments were added to the base procedure. Therefore, the RUC determined that these new codes should continue to be valued the same way endoscopic services were initially valued at the creation of the RBRVS. Finally, the RUC has established valuation of physician work through incremental intra-service work as an approved, viable alternate methodology. In fact, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

45330 Sigmoidoscopy, flexible; diagnostic, collection of specimen(s) by brushing or washing when performed

The RUC reviewed the survey results of 103 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends the following physician time components: pre-service time of 21 minutes, intra-service time of 10 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1A Facility straightforward patient and procedure without sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialty societies that 45330 is currently overvalued, with a work RVU of 0.96. Since the survey respondents overestimated the physician work, the RUC reviewed CPT code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU= 0.84) and agreed that since both these services have identical intra-service time and similar work intensity, they should be valued identically. The RUC agreed that a work RVU of 0.84, a direct crosswalk to code 12001, appropriately valued 45330 to similar services across the RBRVS.

To justify a work RVU of 0.84, the RUC compared the surveyed code to MPC codes 45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing* (work RVU= 0.80, intra time= 10 minutes) and 43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance* (work RVU= 0.90, intra time= 10 minutes) and noted that both these services are similar services with highly analogous times. Therefore, a recommended value of 0.84 appropriately values 45330 in between these MPC services. Finally, to ensure relativity within the endoscopic family, the RUC noted that the recommended RVU of 0.84 places diagnostic flexible sigmoidoscopy appropriately below diagnostic ileoscopy (RUC recommended work RVU= 0.97) and diagnostic esophagoscopy (RUC recommended work RVU= 1.59) in terms of comparative physician work. **The RUC recommends a work RVU of 0.84 for CPT code 45330.**

45331 Sigmoidoscopy, flexible; with biopsy, single or multiple

The RUC reviewed the survey results of 100 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends the following physician time components: pre-service time of 21 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1A Facility straightforward patient and procedure without sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45331. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy biopsy code, 43202 (RUC recommended work RVU= 1.89) should be maintained in this flexible sigmoidoscopy biopsy code. Therefore, the established increment for the physician work related to the biopsy, 0.30 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.14 for CPT code 45331. The RUC agreed with the specialty that the physician work related solely to biopsy is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.14, the RUC compared the surveyed code to CPT codes 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU= 1.10) and 36584 *Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access* (work RVU= 1.20) and agreed that since both codes have identical intra-service time to 45331, 15 minutes, and similar total time, the recommended value appropriately values the surveyed code between these two reference codes. Finally, the RUC reviewed MPC code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01) in comparison to 45331 and noted that while both services have 15 minutes of intra-service time, the surveyed code has more total time than this reference code, 46 minutes compared to 36 minutes, and is thus appropriately valued more. **The RUC recommends a work RVU of 1.14 for CPT code 45331.**

45332 Sigmoidoscopy, flexible; with removal of foreign body

The RUC reviewed the survey results of 64 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends 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 pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because FB removal involves removal of a stent, or devices of various sizes and shapes, in a patient with a narrowing or obstruction of the lumen of the bowel typically resulting from a neoplasm, ischemia, radiation, inflammatory bowel disease, or severe angulation of the bowel.

The RUC first considered three compelling evidence arguments to consider a change in the current work RVU of 1.79 for this service: Change in site-of-service, change in technology and change in types of foreign bodies. There has been a change in the site-of-service for this procedure as 25 years ago, removal of rectal foreign bodies that often required removal under General Anesthesia in the operating room using a rigid proctoscope are now removed in the outpatient setting using a flexible sigmoidoscope. Additionally, new technology for retrieval of rectal foreign bodies is now in use since the prior valuation, including retrieval nets and foreign body balloons. Finally, there are now medical devices requiring removal which did not exist at the prior valuation, including fully coated removable self-expanding metal stents and prostate massage devices for treatment of lower urinary tract symptoms such as benign prostatic hyperplasia, chronic prostatitis/chronic pelvic pain syndrome or bladder conditions such as interstitial cystitis. The variety of rectal foreign bodies inserted by patients are larger, more complex, and more numerous since the prior valuation of this code. The RUC agreed with the specialty societies that there is compelling evidence to consider a change in the current work value for 45332.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45332. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy removal of foreign body code, 43215 (RUC recommended work RVU= 2.60) should be maintained in this flexible sigmoidoscopy hot biopsy code. Therefore, the established increment for the physician work related to removal of a foreign body, 1.01 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.85 for CPT code 45332. The RUC agreed with the specialty that the physician work related solely to foreign body removal is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.85, the RUC compared the surveyed code to CPT codes 32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance* (work RVU= 1.82) and 45317 *Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU= 2.00) and agreed that since both services have identical intra-service time, 20 minutes, and comparable physician work, the

recommended work RVU of 1.85 appropriately values 45332 in between these two reference services. The RUC also reviewed MPC 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, intra time= 20 minutes) and agreed that this reference code should be valued slightly less than the surveyed code due to less total time, 59 minutes and 63 minutes). **The RUC recommends a work RVU of 1.85 for CPT code 45332.**

45333 Sigmoidoscopy, flexible; 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 59 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends 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 and procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45333. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy hot biopsy code, 43216 (RUC recommended work RVU= 2.40) should be maintained in this flexible sigmoidoscopy hot biopsy code. Therefore, the established increment for the physician work related to the hot biopsy, 0.81 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.65 for CPT code 45333. The RUC agreed with the specialty that the physician work related solely to hot biopsy is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.65, the RUC compared the surveyed to CPT code 64448 *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.63, total time= 55 minutes) and agreed that since both services have identical intra-service time, 15 minutes, and analogous total time, the two services should be valued similarly. The RUC also reviewed two MPC codes 57452 *Colposcopy of the cervix including upper/adjacent vagina* (work RVU= 1.50) and 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU= 1.90) and agreed that since both codes have identical intra-service time, and similar total time, compared to 45333, the recommended work value of 1.65 appropriately values this surveyed code between these two reference codes. **The RUC recommends a work RVU of 1.65 for CPT code 45333.**

45334 Sigmoidoscopy, flexible; with control of bleeding, any method

The RUC reviewed the survey results of 71 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends 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 pre-service package 2B Facility difficult patient and

straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient, who may have significant comorbidity, coagulation defects and/or hemodynamic instability, has active gastrointestinal bleeding typically resulting from diverticula, neoplasia, ischemia, radiation, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work RVU of 2.73 overstates the physician work involved in 45334. Since there is no previously established increment for control of bleeding, the RUC reviewed the survey's 25th percentile and determined that a work RVU of 2.10 accurately values this service relative to similar codes in the endoscopic family. To justify a work RVU of 2.10, the RUC compared the surveyed code to CPT codes 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU= 2.00) and 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU= 2.20) and agreed that since both codes have identical intra-service time, 20 minutes, and similar total time, compared to 45334, the recommended work value of 2.10 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70, total time= 60 minutes) and agreed that while the two services have identical intra time and analogous total time, the MPC code should be valued higher than 45334 due to greater physician and intensity to perform the service. **The RUC recommends a work RVU of 2.10 for CPT code 45334.**

45335 Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance

The RUC reviewed the survey results of 63 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends 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 and procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45335. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy submucosal injection code, 43201 (RUC recommended work RVU= 1.90) should be maintained in this flexible sigmoidoscopy submucosal injection code. Therefore, the established increment for the physician work related to the submucosal injection, 0.31 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.15 for CPT code 45335. The RUC agreed with the specialty that the physician work related solely to submucosal injection is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.15, the RUC compared the surveyed CPT code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20*

sq cm or less (work RVU= 1.01) and MPC 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 since these codes all have identical intra-service time, 15 minutes, and provide appropriate reference codes, from across the RBRVS, to bracket the recommended work RVU of 1.15 for 45335. The RUC also reviewed CPT code 57500 *Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)* (work RVU= 1.20, intra time= 15 minutes) and noted that even though the reference code has less pre- and post-service time than 45335, it should still be valued slightly higher due to greater intensity and complexity in the physician work. **The RUC recommends a work RVU of 1.15 for CPT code 45335.**

45337 Sigmoidoscopy, flexible; with decompression of volvulus, any method

The RUC reviewed the survey results of 63 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends the following physician time components: pre-service time of 38 minutes, intra-service time of 25 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient, who may have debility, comorbidity, altered mental status, and/or neurologic deterioration, has a severe megacolon typically resulting from neoplasia, ischemia, strictures, or intestinal motility dysfunction.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work RVU of 2.36 overstates the physician work involved in 45337. Since there is no established increment for this procedure, the RUC reviewed the survey's 25th percentile and determined that a work RVU of 2.20 accurately values this service relative to similar codes in the endoscopic family. To justify a work RVU of 2.20, the RUC compared the surveyed code to CPT codes 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00) and 64517 *Injection, anesthetic agent; superior hypogastric plexus* (work RVU= 2.20) and agreed that since both codes have identical intra-service time, 25 minutes, and similar total time, compared to 45337, the recommended work value of 2.20 appropriately values this surveyed code between these two reference codes. The RUC also reviewed CPT code 45321 *Proctosigmoidoscopy, rigid; with decompression of volvulus* (work RVU= 1.75, intra time= 20 minutes) and noted that while the physician work is comparable, the reference code is appropriately valued less than 45337 because it has 5 minutes less intra-service time. **The RUC recommends a work RVU of 2.20 for CPT code 45337.**

45338 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

The RUC reviewed the survey results of 67 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony

prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has polypoid lesions typically resulting from a neoplasia, pre-neoplasia, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45338. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy snare code, 43217 (RUC recommended work RVU= 2.90) should be maintained in this flexible sigmoidoscopy snare code. Therefore, the established increment for the physician work related to the snare, 1.31 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.15 for CPT code 45338. The RUC agreed with the specialty that the physician work related solely to the snare is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.15, the RUC compared the surveyed code to CPT codes 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU= 2.06) and 92960 *Cardioversion, elective, electrical conversion of arrhythmia; external* (work RVU= 2.25) and agreed that since both codes have identical intra-service time, 15 minutes, and similar total time, compared to 45338, the recommended work value of 2.15 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 2.23, total time= 42 minutes) and noted that while this reference code has less pre- and post-service time compared to 45338, this reference code is appropriately valued higher because the service requires greater intensity and complexity to perform. **The RUC recommends a work RVU of 2.15 for CPT code 45338.**

4534X6 Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

The RUC reviewed the survey results of 49 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends 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 pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has lesions typically resulting from neoplasia, pre-neoplasia, inflammatory bowel disease, or radiation.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 4534X6. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD ablation code, 43270 (RUC recommended work RVU= 4.39) should be maintained in this flexible sigmoidoscopy ablation code. Therefore, the established increment for the physician work related to the ablation, 2.13 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a

recommended work RVU of 2.97 for CPT code 4534X6. The RUC agreed with the specialty that the physician work related solely to ablation is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.97, the RUC compared the surveyed code to CPT codes 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 2.86) and 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that since both codes have identical intra-service time, 20 minutes, and similar total time, compared to 4534X6, the recommended work value of 2.97 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70, total time= 60 minutes) and agreed that while the two services have identical intra time and analogous total time, the surveyed code should be valued slightly higher than this MPC code due to greater physician and intensity to perform the service. **The RUC recommends a work RVU of 2.97 for CPT code 4534X6.**

45340 Sigmoidoscopy, flexible; with transendoscopic balloon dilation

The RUC reviewed the survey results of 58 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has an intermittent bowel obstruction typically resulting from a neoplasm, ischemia, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45340. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy balloon dilation less than 30 mm code, 43220 (RUC recommended work RVU= 2.10) should be maintained in this flexible sigmoidoscopy balloon dilation code. Therefore, the established increment for the physician work related to balloon dilation, 0.51 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.35 for CPT code 45340. The RUC agreed with the specialty that the physician work related solely to balloon dilation is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.35, the RUC compared the surveyed code to CPT codes 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report* (work RVU= 1.28) and 32560 *Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)* (work RVU= 1.54) and agreed that since both codes have identical intra-

service time, 20 minutes, and similar total time, compared to 45340, the recommended work value of 1.35 appropriately values this surveyed code between these two reference codes. Finally, the RUC reviewed MPC code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU= 1.14) and agreed that that since this code has less intra-service time, 15 minutes, compared to 45340, the recommended value of 1.35 accurately values this surveyed code higher than this MPC code. **The RUC recommends a work RVU of 1.35 for CPT code 45340.**

4534X7 Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

The RUC reviewed the survey results of 57 gastroenterologists and several surgical subspecialties including: general, gastrointestinal, endoscopic and colorectal and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the reason for placement of a stent is that the patient has a narrowing or obstruction of the lumen of the bowel resulting from a neoplasm.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 4534X7. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD endoscopic stent placement code, 43266 (RUC recommended work RVU= 4.40) should be maintained in this flexible sigmoidoscopy endoscopic stent placement code. Therefore, the established increment for the physician work related to endoscopic stent placement, 2.14 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.98 for CPT code 4534X7. The RUC agreed with the specialty that the physician work related solely to placement of an endoscopic stent is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.98, the RUC compared the surveyed code to CPT code 37214 *Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method* (work RVU= 2.74) and noted that while the reference code has greater intra-service time, 38 minutes compared to 35 minutes, the physician work involved in 4534X7 is more intense and complex than in the reference code. Therefore, the surveyed code is accurately valued higher than this reference code. The RUC also reviewed MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80) and agreed that with

higher intra-service time, 40 minutes, the reference code is accurately valued higher than 4534X7. **The RUC recommends a work RVU of 2.98 for CPT code 4534X7.**

Practice Expense:

The Practice Expense Subcommittee reviewed the direct practice expense inputs for the flexible sigmoidoscopy services and noted that these services mostly crosswalk from the EGD codes approved last year. In general, the total clinical staff times were either slightly lower or just about the same as the current inputs. The largest change was the addition of 30 minutes for staff to clean the scope. There were several modifications to supplies for a small subset of codes to match refinements made to the EGD codes approved in the previous year. Finally, the Subcommittee noted that several supplies and equipment were newly submitted to CMS for pricing just last year. Since new codes were not available prior to the meeting, they are listed as new and will be revised when CMS releases the codes. There is one new equipment item specifically related to these types of procedures (videoscope, sigmoidoscopy) and one item related to only CPT code 43270 (radiofrequency generator, endoscopy). Appropriate invoices are attached. The RUC approved the revised PE spreadsheet as modified by the PE Subcommittee.

Extant Databases:

The RUC is aware that several databases currently exist that collect physician time and other patient quality-related information for endoscopy services. The specialty societies were queried about the availability of these databases to be used to inform the RUC during this extensive review of all endoscopy procedures. The specialties explained that these databases currently do not have a standard definition of intra-service work and are not publically available at this time.

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.

Do Not Use to Validate:

The specialties requested, and the RUC agreed, that CPT code 45338 should have a note in the RUC database that states this code should not be used to validate for physician work. The specialties stated that an intra-service time of 15 minutes underrepresents the physician work involved in the snare technique, especially compared to other endoscopic snare codes.

Dual Energy X-Ray (Tab 7)

Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Howard Lando, MD (AACE); Timothy Laing, MD (ACRh); Scott C. Bartley, MD (ACNM); Allan Glass, MD (TES)

For calendar years 2010 and 2011, the Affordable Care Act (ACA) modified the payment for dual X-ray absorptiometry (DXA) services described by 77080 and 77082 to 70 percent of the product of the CY 2006 RVUs for these services, the CY 2006 conversion factor and the geographic adjustment for the relevant payment year. The ACA also allowed for a study to be conducted on the ramifications of Medicare payment reductions for DXA on beneficiary access to bone mass density tests. As of 2011, the study had not been initiated. Therefore, CMS requested that the AMA RUC review CPT codes 77080 and 77082.

The RUC understood that there were duplicate practice expense items that CMS corrected several years ago, which led to a significant reduction in payment. However, Congress reversed this payment reduction. The Congressional correction expired on December 31, 2011. The RUC reviewed the physician work and practice expense for CPT codes 77080 and 77082 in January 2012 and submitted recommendations to CMS for CPT 2013. The RUC recommendations were not to establish the payment but the correct physician work and practice expense required to perform a service.

In October 2012, CPT codes 77082 and 77080 were identified by the Joint CPT/RUC Workgroup, which recommended creating a code bundling solution by the 2015 CPT cycle. In May 2013, the CPT Editorial Panel established a bundled code to report DXA bone density study of axial skeleton with vertebral fracture assessment; deleted code 77082 and replaced with new code 7708X2; and added a parenthetical note following 77080 to clarify reporting of DEXA services.

77080 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

In October 2013, the RUC reviewed the survey results from 91 physicians and recommends maintaining the current work RVU of 0.20 for CPT code 77080. The survey respondents indicated a work RVU median of 0.27 and 25th percentile of 0.22. The specialty societies indicated and the RUC agreed that the physician work required to perform this service has not changed and therefore there is no compelling evidence to increase the work RVUs for this service. The specialty societies recommended and the RUC agreed that the physician time of 2 minutes pre-time, 5 minutes intra-time and 2 minutes immediate post-time be maintained. The RUC compared CPT code 77080 to key reference service 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU = 0.22) and noted that the current work RVU for 77080 maintains the appropriate relativity in relation to this family of services and other similar services. For additional support to maintain the current work RVU, the RUC referenced similar service 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (work RVU = 0.27) and noted that 74020 is more intense to perform than 77080. The RUC noted that 77080 is slightly more intense and complex than 7708X2 due to the body sites examined and therefore should be valued slightly higher. **The RUC recommends a work RVU of 0.20 for CPT code 77080.**

7708X1 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment

In October 2013, the RUC reviewed the survey results from 90 physicians and recommends the survey 25th percentile work RVU of 0.30 and 3 minutes pre-time, 8 minutes intra-time and 3 minutes immediate post-time for CPT code 7708X1. CPT code 7708X1 represents the bundling of DXA axial with a vertebral fracture assessment when performed on the same date of service. The RUC compared CPT code 7708X1 to key reference service 72052 *Radiologic examination, spine, cervical; 6 or more views* (work RVU = 0.36) and determined that 7708X1 is less intense and requires less physician work to perform than CPT code 72052. For further support, the RUC referenced MPC code 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVU = 0.30) which requires the same physician work and similar physician time to perform. **The RUC recommends a work RVU of 0.30 for CPT code 7708X1.**

7708X2 Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)

In October 2013, the RUC reviewed the survey results from 88 physicians and recommends a work RVU of 0.17 and 2 minutes pre-time, 5 minutes intra-time and 2 minutes immediate post-time, for CPT code 7708X2. The survey respondents indicated a work RVU median of 0.22 and 25th percentile of 0.18. The specialty societies indicated and the RUC agreed that the physician work required to perform this service has not changed compared to previously described code 77082 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment* (work RVU = 0.17). The RUC compared CPT code 7708X2 to key reference service 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU = 0.22) and noted that a work RVU of 0.17 maintains the appropriate relativity in relation to this family of services and other similar services. For additional support, the RUC referenced similar service 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (work RVU = 0.27) and noted that 74020 is more intense to perform than 7708X2. **The RUC recommends a work RVU of 0.17 for CPT code 7708X2.**

Practice Expense:

The practice expense was recently refined by CMS for CY 2013. However, due to the Migration of Radiologic Images from Film to Digital Workgroup recommendations, lines 12 and 13 were added to specify the pre-service time of the clinical labor staff: 1) Availability of prior electronic images confirmed and 2) Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocolled by radiologist. The Practice Expense Subcommittee determined a standard of 2 minutes for each of these line items is appropriate for 77080 and 7708X2, with 3 minutes allotted for 7708X1. Secondly, lines 37, 38 and 39 were added to specify clinical labor staff post-service activities: 1) Technologist QC's images in PACS, checking for all images, reformats, and dose page; 2) Review examination with interpreting MD; and 3) Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue. The Practice Expense Subcommittee confirmed that the typical clinical staff for these services is a Radiation Technologist because the typical setting is in a diagnostic radiology office. **The RUC accepted the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.**

Work Neutrality:

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

In Situ Hybridization (Tab 8)

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

In the Proposed Rule for the 2012 MFS, CMS received comments that unlike the new FISH codes for urinary tract specimens, 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* and 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology*, the existing codes 88365 *In situ hybridization (eg, FISH), each probe*, 88367 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology* and 88368 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; manual*

still allow for multiple units of each code as these codes are reported per probe. CMS stated that they reviewed the current work and practice costs associated with 88120 and 88121 and agreed that they were accurate. In January 2012, the RUC recommended that it re-review codes 88365, 88367 and 88368 at the April 2013 meeting. At the April 2013 meeting, upon careful review of the code descriptors and other vignettes, it was determined that the entire family of services should be referred to the CPT Editorial Panel to accurately describe typical services. In May 2013, the CPT Editorial Panel revised the in situ hybridization codes 88365, 88367 and 88368 to specify “each separately identifiable probe per block” and created three new add-on codes 8836X6, 8836XX and 8836X9 “to specify each additional separately identifiable probe per slide”. In addition, the panel revised and added relevant parenthetical notes to instruct on the proper use of these codes.

The RUC noted that CPT code 88365 is typically used to assist in making a cancer diagnosis, whereas, CPT codes 88367 and 88368 are typically used to assist in determining treatment and management of the patient’s cancer. There was concern among the RUC that the physician time of 20 minutes for 88365 may have been overestimated compared to 88367 and 88368 since this represents a qualitative test and results are reported as either positive or negative. The specialty society confirmed that although this is a qualitative test, the pathologist is required to review the entire slide to determine if the test may be interpreted as positive or negative and that these results assist in determining a diagnosis. The RUC also discussed the physician time across this family, specifically regarding the add-on codes. The survey results indicate an intra service time of 20 minutes for add-on CPT code 8836X6 and 15 minutes for add-on codes 8836XX and 8836X9. The specialty society stated, and the RUC agreed, that the time of the add-on codes should mirror that of the base codes since the work and intensity are the same. Although the pathologist is familiar with the specimen, the results of both the base and add-on code need to be aggregated and integrated. The RUC noted that, since their initial valuation, the physician time for 88365, 88367 and 88368 has been markedly reduced from 40, 42 and 45 respectively to 20 minutes. However, when these services were originally reviewed in 2004, pre-time and post-time was collected and added to intra-service time as opposed to the current pathology standard employed for these codes which is to survey only for intra-service work. The RUC agreed that the physician work of these codes has not changed since these codes were originally reviewed.

88365 In situ hybridization (eg, FISH), each separately identifiable probe per block, cytologic preparation, or hematologic smear; first separately identifiable probe per slide

The RUC reviewed the survey results from 37 pathologists and agreed that a work RVU of 0.86, the survey 25th percentile is appropriate. The RUC agreed with the specialty society that the current work RVU of 1.20 overestimated physician work in comparison to other similar services. Specifically, the RUC reviewed key reference code 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU=1.20) and agreed that 88120 should be valued higher since it requires more physician time. The RUC also reviewed code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (work RVU=0.69) and agreed that although both require 20 minutes, 88365 is a more intense service. In addition, the RUC reviewed MPC codes 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU=0.81) and 76805 *Ultrasound,*

pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation (work RVU=0.99) and determined that these two services require similar intensity and total time. **The RUC recommends a work RVU of 0.86 for CPT code 88365.**

8836X6 In situ hybridization (eg, FISH), each separately identifiable probe per block, cytologic preparation, or hematologic smear; each additional identifiable probe per slide (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 37 pathologists and agreed that a work RVU of 0.86, which is below the survey 25th percentile, is appropriate. The RUC determined that since 88365 and the add-on code, 8836X6 require the identical time and intensity, these two services should be valued the same. The RUC noted that the pathologist is looking at a second probe with an entirely different color signal on the same slide as the base code, 88365. The RUC reviewed CPT code 88177 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)* (work RVU=0.42) and agreed that 88177 requires less physician time and intensity. In addition, the RUC reviewed MPC codes 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU=0.81) and 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU=0.99) and determined that these two services require similar intensity and total time. **The RUC recommends a work RVU of 0.86 for CPT code 8836X6.**

88367 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, each separately identifiable probe per block, cytologic preparation, or hematologic smear; first separately identifiable probe per slide

The RUC reviewed the survey results and agreed that a work RVU of 0.86, which is below the survey 25th percentile, is appropriate. The RUC noted that this service is performed by a limited number of pathologists and the computer-assisted technology has not been widely adopted. There was concern that the computer assisted test was less intense, however, the specialty society confirmed that the computer assisted test simply assists the physician and does not replace the physician work. The machine does not adequately distinguish between cancer and non-cancer cells. In addition, the American Society of Clinical Oncology (ASCO) guidelines indicate that a minimum of 40 neoplastic cells need to be examined for signal intensity. The RUC determined that since 88367 and 88365 require the same physician work and intensity, these two services should be valued the same. The RUC reviewed code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (work RVU=0.69) and agreed that although both require 20 minutes, 88365 is a more intense service. To further support this recommendation, the RUC reviewed MPC codes 78306 *Bone and/or joint imaging; whole body* (work RVU=0.86) and 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU=0.99) and determined that these two services require similar intensity and total time. **The RUC recommends a work RVU of 0.86 for CPT code 88367.**

8836XX Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, each separately identifiable probe per block, cytologic preparation, or hematologic smear; each additional identifiable probe per slide (List separately in addition to code for primary procedure)

The RUC reviewed the survey results and agreed that a work RVU of 0.65, which is below the survey 25th percentile, is appropriate. The RUC noted that this service is performed by a limited number of pathologists and the computer-assisted technology has not been widely adopted. The RUC noted concern that the computer assisted test was less intense, however, the specialty society confirmed that the computer assisted test simply assists the physician and does not replace the physician work. The machine does not adequately distinguish between cancer and non-cancer cells. In addition, the American Society of Clinical Oncology (ASCO) guidelines indicate that a minimum of 40 neoplastic cells need to be examined for signal intensity. The RUC determined that since 8836XX requires 15 minutes of physician time compared to 20 minutes required to perform 88367, the work RVU of 0.86 should be reduced by 25%. The RUC reviewed code 88177 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)* (work RVU=0.42) and agreed that although both require 15 minutes, the work of 8836XX is more intense. The RUC also reviewed MPC CPT code 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses* (work RVU = 0.65) and agreed to the similarities of the overall physician work and time amongst 76815 and 8836XX. **The RUC recommends a work RVU of 0.65 for CPT code 8836XX.**

88368 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, each separately identifiable probe per block, cytologic preparation, or hematologic smear; first separately identifiable probe per slide

The RUC reviewed the survey results from 48 pathologists and agreed that a work RVU of 0.86, which is below the survey 25th percentile, is appropriate. The RUC determined that since 88368 requires the same physician work and intensity as 88365 and 88367, these services should be valued the same. The RUC reviewed code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (work RVU=0.69) and agreed that although both require 20 minutes, 88365 is a more intense service. To further support this recommendation, the RUC reviewed MPC codes 78306 *Bone and/or joint imaging; whole body* (work RVU=0.86) and 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU=0.99) determined that these two services require similar intensity and total time. **The RUC recommends a work RVU of 0.86 for CPT code 88368.**

8836X9 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, each separately identifiable probe per block, cytologic preparation, or hematologic smear; each additional identifiable probe per slide (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 48 pathologists and agreed that a work RVU of 0.65, which is below the survey 25th percentile, is appropriate. The RUC determined that since 8836X9 requires 15 minutes of physician time compared to 20 minutes for 88368, the work RVU of 0.86 should be reduced by 25%. The RUC reviewed codes The

RUC reviewed code 88177 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)* (work RVU=0.42) and agreed that although both require 15 minutes, the work of 8836XX is more intense.

The RUC also reviewed MPC CPT code 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses* (work RVU = 0.65) and agreed to the similarities of the overall physician work and time amongst 76815 and 8836X9. **The RUC recommends a work RVU of 0.65 for CPT code 8836X9.**

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:

The Practice Expense Subcommittee reviewed the direct practice expense inputs for the in situ hybridization services and made a few minor modifications. Specifically, under the post service period, "manage any relevant utilization review/quality assurance activities and regulatory compliance documentation" was deleted since this is not applicable to every slide or patient. In addition, under medical supplies, "label microscope slides" was considered duplicative, and therefore, deleted. It was noted that 4.5 ml of bleach was missing from CPT code 8836XX and 250 ml of ethanol was appropriately allocated to the base codes, 88365 and 88368 as opposed to the add-on codes. The CoPath System and Software were added, but are pending approval from CMS. Lastly, the Practice Expense Subcommittee confirmed that there was neither overlap of work between the physician and technologist nor duplication of other pathology services performed on the same day. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Negative Pressure Wound Therapy (Tab 9)

The specialty societies determined the need to go to the Research Subcommittee with a request to revise the vignettes to reflect the typical patient and obtain approval for a non-random survey sample. Additionally, codes 97605 and 97606 were placed on the Relativity Assessment LOI for review. The RUC will review the two new negative wound pressure therapy codes and existing codes 97605 and 97606 at the January 2014 RUC meeting.

IX. CMS Request/Relativity Assessment Identified Codes

Arteriovenous Anastomosis (Tab 10)

Matthew Sideman, MD (SVS), Robert Zwolak, MD (SVS); Gary Seabrook, MD (SVS); Michael Sutherland, MD (SVS); David Han, MD (SVS); Charles Mabry, MD (ACS); Christopher Senkowski, MD (ACS)

Facilitation Committee #2

In the CY 2013 Medicare Proposed Rule, CMS initially stated that the agency did not consider CPT codes 36819 and 36825 to be potentially misvalued because these codes were last reviewed and valued for CY 2012 and the supporting documentation did not

provide sufficient evidence to demonstrate that the codes should be reviewed as potentially misvalued for CY 2013 or CY 2014. However, after reviewing the comments received and conducting a clinical review of CPT codes 36819 and 36825 alongside similar services, CMS determined that the entire family of services may be out of rank order and are potentially misvalued. CMS requested review of CPT codes 36819 and 36825 along with their code families, which includes CPT codes 36818 through 36821 and CPT codes 36825 through 36830, as potentially misvalued. The specialty societies added codes 36831-36833 as a related family of services. CMS requested additional comments on the appropriate physician work and direct PE inputs for these services. In January 2013, the RAW agreed with the specialty societies to survey physician work and develop PE inputs for review at the October 2013 RUC meeting.

Creation of Hemodialysis Access Procedures

The specialty societies noted that there are a total of six codes in the hemodialysis access code family. This is the first time in which all six codes were surveyed together. The RUC recognizes that in order to reinstate the proper rank order within this family of services, the current surveys confirm that the work RVU should be increased for three services and be decreased for the remaining three services in this family. The specialty societies indicated and the RUC agreed that there is compelling evidence that the work has changed for these services due to:

1. Flawed methodology – CMS conducted a reverse building block calculation to develop the current work RVU for CPT code 36819. This code was valued using magnitude estimation twice; it was not created via building block methodology. The RUC agreed and noted that it has a long standing policy that reverse building block is not an appropriate method of valuation when a code is not created that way.
2. Rank order anomalies – CPT code 36819 is more complex to perform than 36820. However the current value for 36820 (2013 work RVU = 14.47) is higher than 36819 (2013 work RVU = 13.29). Also, 36818 (2013 work RVU = 11.89) is currently below the base code 36821 (2013 work RVU = 12.11) even though code 36818 includes the work of 36821, in addition to the physician work to perform the vein transposition.
3. Change in patient population – the “Fistula First” breakthrough initiative has radically changed the approach to treating hemodialysis patients and how these surgeries are performed. Patients who may not have received fistulas previously because of age, comorbidities and/or marginal vein, are now undergoing autogenous access procedures successfully. Some of these services have been reviewed since the Fistula First initiative and the RUC and CMS agreed with this compelling argument; other codes in the family have not been reviewed since the Fistula First initiative.

36818 Arteriovenous anastomosis, open; by upper arm cephalic vein transposition

The specialty societies indicated and the RUC agreed that there is a rank order anomaly with the current work RVU of 11.89 for code 36818 in relation to the base code 36821. The RUC reviewed the survey results from 34 vascular and general surgeons for CPT code 36818 and agreed that the survey 25th percentile work RVU of 13.00 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with

the survey median response. The RUC noted that the additional pre-time is consistent with other similar services. The RUC recommends 75 minutes pre-service time, 90 minutes intra-service time and 25 minutes post-service time.

The RUC compared 36818 to reference service 35206 *Repair blood vessel, direct; upper extremity* (work RVU = 13.84) and noted that that these services have the same intra-service time of 90 minutes, require similar intensity to perform and have the same post-operative office visits. Thus, the RUC determined that the work RVUs for these two services should be similar. The RUC also compared 36818 to MPC codes 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (work RVU = 12.16 and 90 minutes intra-service time) and 33249 *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber* (work RVU = 15.17 and 120 minutes intra-service time) and determined a work RVU of 13.00 for CPT code 36818 is appropriate using magnitude estimation in relation to other similar services. **The RUC recommends a work RVU of 13.00 for CPT code 36818.**

36819 Arteriovenous anastomosis, open; by upper arm basilic vein transposition

The RUC noted that this is a complex service that requires extensive work to transpose the upper arm vein. The RUC reviewed the survey results from 34 vascular and general surgeons and agreed that the survey 25th percentile work RVU of 15.00 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with the survey median response. The RUC noted that the additional pre-time is consistent with other similar services. The RUC recommends 75 minutes pre-service time, 120 minutes intra-service time and 30 minutes post-service time.

The RUC noted that CPT code 36819 (2013 work RVU = 13.29) is currently valued lower than 36820 (2013 work RVU = 14.47), even though 36819 is a more complex procedure. The new survey data supports this with 20 additional intra-service minutes for 36819 (120 minutes) compared to 36820 (100 minutes). The RUC compared code 36819 to key reference code 34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision* (work RVU = 19.48) and noted that while both these codes are vascular procedures, CPT code 34201 is procedure in the lower extremity for thrombosis and does not involve the creation of a functional arteriovenous hemodialysis access. CPT code 34201 requires similar intra-service time as 36819, 128 and 120 minutes, respectively. However, 34201 requires four hospital post-operative visits. Thus, the RUC determined 36819 appropriately requires less work than key reference code 34201. The RUC also compared 36819 to MPC code 33249 *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber* (work RVU = 15.17 and 120 minutes intra-service time), 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU = 15.00 and 90 minutes intra-service time) and 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and*

transurethral resection of prostate are included if performed) (work RVU= 14.56 and 120 minutes intra-service time). **The RUC recommends a work RVU of 15.00 for CPT code 36819.**

36820 Arteriovenous anastomosis, open; by forearm vein transposition

The RUC reviewed the survey results from 34 vascular and general surgeons for CPT code 36820 and determined the physician work required to perform this service is slightly lower than the survey 25th percentile (15.00) and current work RVU (14.47). The RUC agreed with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with the median survey response. The RUC recommends 75 minutes pre-service time, 100 minutes intra-service time and 25 minutes post-service time.

The RUC noted that CPT code 36819 (2013 work RVU = 13.29) is currently valued lower than 36820 (2013 work RVU = 14.47), even though 36819 is a more complex procedure. The new survey data supports this with 20 additional intra-service minutes for 36819 (120 minutes) compared to 36820 (100 minutes). In order to maintain rank order within this family of services the RUC recommends crosswalking 36820 to similar service 19302 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy* (work RVU = 13.99 and 100 minutes intra-service time). The current total time for 36820 includes inpatient post-operative visits. The specialty recommended and the RUC agreed to remove the inpatient post-operative visits because that is not current practice anymore. Removing the hospital visits caused an increase in IWP/UT (0.099), which falls in line with the rest of this family of services. The physician intra-service time is decreasing but the intensity is increasing because the change in patient population as indicated in the compelling evidence above. **The RUC recommends a work RVU of 13.99 for CPT code 36820.**

36821 Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)

The RUC reviewed the survey results from 60 vascular and general surgeons for CPT code 36821, the most commonly reported fistula creation code and the base code for this family. For CPT code 36821, the physician is connecting any vein to any artery in close proximity, typically brachial cephalic or radial cephalic fistula. The specialty societies recommended and the RUC agreed that the survey 25th percentile work RVU of 11.90, a decrease in the current value, appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with the survey median response. The RUC noted that the additional pre-time is consistent with other similar services. The RUC recommends 75 minutes pre-service time, 75 minutes intra-service time and 25 minutes post-service time.

The RUC compared code 36821 to key reference code 35206 *Repair blood vessel, direct; upper extremity* (work RVU = 13.84) and noted that 35206 is a repair code for injury to the arteries in the upper extremity and does not involve creation of a functional arteriovenous hemodialysis access, but requires 15 minutes more intra-service time to perform and two 99231 hospital post-operative visits. Thus, the RUC determined 36821 appropriately requires less work than key reference code 35206. The RUC also compared 36821 to MPC code 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (work RVU = 12.16 and 90 minutes intra-service time) and similar services 59150 *Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy* (work RVU = 12.29 and 70 minutes intra-service time); 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (work RVU= 13.16 and 75 minutes intra-service time); 38760 *Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)* (work RVU = 13.62 and 70 minutes intra-service time) and determined the recommended work RVU of 11.90 for CPT code 36821 is appropriate using magnitude estimation in relation to other similar services. **The RUC recommends a work RVU of 11.90 for CPT code 36821.**

36825 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft

The RUC reviewed the survey results from 34 vascular and general surgeons for CPT code 36825 and determined that the survey 25th percentile work RVU of 15.93 appropriately accounts for the work required to perform this service. The RUC noted that this service is the most complex service of the autogenous fistulas and a work RVU of 15.93 supports rank order and magnitude estimation for this family of services.

The RUC agreed with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with the survey median response. The RUC noted that the additional pre-time is consistent with other similar services. The RUC recommends 75 minutes pre-service time, 120 minutes intra-service time and 30 minutes post-service time.

The RUC also compared code 36825 to key reference code 35656 *Bypass graft, with other than vein; femoral-popliteal* (work RVU = 20.47) and noted that 35656 is a nonautogenous bypass code for the lower extremity, but requires 30 minutes more intra-service time to perform and five 99231 hospital post-operative visits. Thus, the RUC determined 36825 appropriately requires less work than key reference code 35656. The RUC also compared 36825 to MPC codes 33249 *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber* (work RVU = 15.17 and 120 minutes intra-service time) and 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)*; (work RVU = 17.31 and 120 minutes intra-service time) and determined a work RVU of 15.93 for CPT code 36825 is appropriate using magnitude estimation in relation to other similar services. **The RUC recommends a work RVU of 15.93 for CPT code 36825.**

36830 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)

The RUC reviewed the survey results from 60 vascular and general surgeons for CPT code 36830, the second most commonly performed service in this family and the only code that describes creation of arteriovenous fistula using a nonautogenous graft. The RUC agreed with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with the survey median response. The RUC noted that the additional pre-time is consistent with other similar services. The RUC recommends 75 minutes pre-service time, 90 minutes intra-service time and 25 minutes post-service time.

The RUC compared 36830 to 36821 determined that 36830 should be valued the same as 36821 at 11.90 work RVUs. CPT codes 36821 and 36830 require the same pre-service and post-service time. CPT code 36821 requires 75 minutes intra-service time, whereas CPT code 36830 requires 90 minutes intra-service time, thus 36821 results in higher IWP/UT (0.086 and 0.104 respectively). The specialties indicated and the RUC agreed that the difference in intra-service time and intensity are appropriate because two vascular anastomoses are performed in 36830 resulting in a longer intra-time; however, the conduit is synthetic and therefore the procedure has a lower intensity compared to mobilizing a native vein for arteriovenous anastomosis in 36821.

The RUC referenced CPT code 49560 *Repair initial incisional or ventral hernia; reducible* (work RVU = 11.90 and 90 minutes intra-time), which supports the recommended work RVU of 11.90. The RUC also compared code 36830 to key reference code 35656 *Bypass graft, with other than vein; femoral-popliteal* (work RVU = 20.47) and noted that that 35656 is a nonautogenous bypass code for the lower extremity, but requires 60 minutes more intra-service time to perform and five 99231 hospital visits. Thus, the RUC determined 36830 appropriately requires less work than key reference code 35656. The RUC also compared 36830 to MPC codes 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)* (work RVU = 11.59 and 90 minutes intra-service time) and 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (work RVU = 12.16 and 90 minutes intra-service time) and determined the recommended work RVU of 11.90 for CPT code 36830 is appropriate using magnitude estimation in relation to other similar services. **The RUC recommends a work RVU of 11.90 for CPT code 36830.**

Revision of Hemodialysis Access Procedures

The RUC noted that codes 36831-36833 have not been surveyed since 1998. The specialty societies indicated and the RUC agreed that there is compelling evidence that the work has changed for these services due to:

1. Significant change in patient population - the “Fistula First” breakthrough initiative has radically changed the approach to treating hemodialysis patients and how these surgeries are performed. Patients who may not have received fistulas previously are now and receiving and being treated successfully. This initiative has placed a priority on creating

- fistulas, thus creating more revisions fistulas on the dialysis population. There has been an increase to revise, what would have previously been deemed marginal veins with questionable access. Now there has been a priority on maintaining these accesses. In past failed fistulas would be abandoned and new accesses placed. Now physicians are surveilling fistulas, salvaging failing fistulas and restarting failed fistulas. There has also been a growth of endovascular techniques. Now, dialysis patients are intervened percutaneously with angioplasty, stenting or undergo percutaneous thrombectomy to maintain function of these accesses. The typical patients are treated in the manner selecting out the endovascular failures or complex patients for open surgical revision. This represents a significant change in the patient population and a change in the work.
2. Incorrect Assumptions - these services are predominately outpatient services and should have half a discharge day management visit, which is currently not present in the time and visits data. Additionally, the post-operative visits are not consistent with the survey respondents or current practice.

36831 Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)

The RUC reviewed the survey results from 36 vascular and general surgeons for CPT code 36831 and determined that the survey 25th percentile work RVU of 11.00 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with the survey median response. The RUC noted that the additional pre-time is consistent with other similar services. The RUC recommends 75 minutes pre-service time, 85 minutes intra-service time and 30 minutes post-service time. The specialties indicated and the RUC agreed that the increase in post-operative office visits appropriately reflects the shift in the patient population for these services because more attention is necessary to keep the access sites working, requiring more follow-up visits.

The RUC noted that the intra-service time has increased by 15 minutes from when it was previously reviewed in 1998. The specialty societies indicated and the RUC agreed that this increase is appropriate as the patient population has changed. The typical patient receiving this service today has already been treated by an interventionist who attempted a percutaneous intervention that failed. The access has been manipulated recently and is more difficult than the cases 15 years ago, thus, the procedure takes more time and work. The RUC compared code 36831 to key reference code 34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision* (work RVU = 19.48) and noted that that 34201 is similar in that they are both vascular procedures. However, CPT code 34201 is a procedure in the lower extremity for thrombosis and does not involve the creation of a functional arteriovenous hemodialysis access. CPT code 34201 also requires 43 minutes more intra-service time to perform and four hospital visits. Thus, the RUC determined 36831 appropriately requires less work than key reference code 34201. The RUC also compared 36831 to MPC codes 21015 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm* (work RVU = 9.89 and 75 minutes intra-service time) and 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (work

RVU = 12.16 and 90 minutes intra-service time) and determined the recommended work RVU of 11.00 for CPT code 36831 is appropriate using magnitude estimation in relation to other similar services. **The RUC recommends a work RVU of 11.00 for CPT code 36831.**

36832 Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

The RUC reviewed the survey results from 37 vascular and general surgeons for CPT code 36832 and determined that the survey 25th percentile work RVU of 13.50 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with the survey median response. The RUC noted that the additional pre-time is consistent with other similar services. The RUC recommends 75 minutes pre-service time, 90 minutes intra-service time and 30 minutes post-service time.

The specialty societies noted that the nature of this procedure has changed since 1998. Previously, the typical patient had stenosis of a fistula in which the physician patched or revised. Now, those cases are all treated with angioplasty or stenting. Currently, the typical patient has a functioning access that is too deep in a large arm (i.e., obese patient) that cannot be reliably accessed. The nephrologist cannot use the access because a needle will not enter the vein. The physician must mobilize the entire access and move it closer to the skin to be functionally utilized. This represents an increase in physician work from the work required in 1998. The specialties indicated agreed that the increase in post-operative office visits appropriately reflects the shift in the patient population for these services because more attention is focused on keeping the access working, therefore more follow-up visits are required.

The RUC compared code 36832 to key reference code 35206 *Repair blood vessel, direct; upper extremity* (work RVU = 13.84) and noted that that these services have different post-operative hospital and office visits, but have the same intra-service time of 90 minutes and require similar intensity to perform. Thus, the RUC determined that the work RVUs for these two services should be similar. The RUC also compared 36832 to MPC codes 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (work RVU = 12.16 and 90 minutes intra-service time) and 33249 *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber* (work RVU = 15.17 and 120 minutes intra-service time) and determined a work RVU of 13.50 for CPT code 36832 is appropriate using magnitude estimation in relation to other similar services. **The RUC recommends a work RVU of 13.50 for CPT code 36832.**

36833 Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

The RUC reviewed the survey results from 37 vascular and general surgeons for CPT code 36833 and determined that the survey 25th percentile work RVU of 14.50 appropriately accounts for the work required to perform this service. The RUC agreed

with the specialty societies that pre-service package 4 *Facility Difficult Patient/Difficult Procedure*, is appropriate with an additional 10 minutes of pre-evaluation time to review the extensive pre-operative venous and arterial mapping, testing and ultrasounds to determine suitable venous and arterial anatomy; an additional 7 minutes of pre-positioning time to attach the arm table on the operating table and positioning the arm appropriately to prevent abnormal joint extension, nerve traction or pressure on bony landmarks; and a reduction of 5 minutes pre-scrub/dress/wait time to be consistent with the survey median response. The RUC noted that the additional pre-time is consistent with other similar services. The RUC recommends 75 minutes pre-service time, 120 minutes intra-service time and 30 minutes post-service time. The specialties indicated agreed that the increase in post-operative office visits appropriately reflects the shift in the patient population for these services because more attention is focused on keeping the access working, therefore more follow-up visits are required.

The RUC compared code 36833 to key reference code 34201 *Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision* (work RVU = 19.48) and noted that 36833 and 34201 require similar intensity and intra-service time, 120 and 128 minutes, respectively, to perform. However, CPT code 34201 requires four hospital post-operative visits. Thus, the RUC determined that the work RVUs for reference code 34201 is appropriately higher. The RUC also compared 36833 to MPC code 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (work RVU = 12.16 and 90 minutes intra-service time); MPC code 33249 *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber* (work RVU = 15.17 and 120 minutes intra-service time) and similar service 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56 and 120 minutes intra-service time) and determined a work RVU of 14.50 for CPT code 36833 is appropriate using magnitude estimation in relation to other similar services. **The RUC recommends a work RVU of 14.50 for CPT code 36833.**

Practice Expense:

The RUC accepted the standard 090-day global direct practice expense inputs as approved by the Practice Expense Subcommittee.

Vitrectomy (Tab 11)

Stephen A. Kamenetzky, M.D. (AAO); Trexler M. Topping, M.D. (AAO); John T. Thompson, M.D (AAO)

Facilitation Committee #2

In October 2012, CPT code 67036 was identified through the Harvard-Valued Annual Allowed Charges Greater than \$10 million screen. The RUC recommended that this family of services be surveyed for physician work and that the direct practice expense inputs be reviewed for the October 2013 RUC meeting.

The RUC discussed why the physician time has decreased from that of the Harvard Studies physician time. The specialty societies indicated and the RUC agreed that the technique and technology has improved over the last 20 years. Previously, these procedures required a lot of opening, suturing and performing the operation. Previously

physicians used larger instruments; whereas now the physician uses small-gauge trocar cannula instruments that typically do not require sutures after removal because they are held in place by friction. Additionally, physicians now use wide angle illumination systems which allow the physician to go further and get closer to the surface of the retina, which is also riskier. The Harvard times were longer due to the multi-layer suturing involved and more laborious instruments used. Now, the time is lower but more intense with all the work focused on the procedure itself instead of opening and closing incisions. The RUC noted that these vitrectomy procedures are very intense and complex due to the proximity of the retina and risk of causing central vision loss.

The RUC also discussed the level of post-operative office visits required for these procedures. The specialty societies indicated and the RUC agreed that a full dilated eye exam is performed at every visit in order to see the retina. Therefore, a 99213 Evaluation and Management office visit is necessary for each of the five post-operative visits to incorporate the time required to perform a fully dilated eye exam.

67036 Vitrectomy, mechanical, pars plana approach;

The RUC reviewed the survey results from 148 ophthalmologists and retina specialists and determined that the respondents overestimated the work required to perform this service. The key reference service 67113 *Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens* (work RVU = 23.35 and 130 minutes intra-service) is more intense, requires significantly more work and significantly more physician time to perform than 67036. Therefore, the RUC recommends directly crosswalking 67036 to 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU=12.13 and 60 minutes intra-service time) as both services require the same intensity to perform and maintains the proper rank order among this family of services. **The RUC recommends a work RVU of 12.13 for CPT code 67036.**

67039 Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation

The RUC reviewed the survey results from 127 ophthalmologists and retina specialists and determined that the respondents overestimated the work required to perform this service. The key reference service 67113 *Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens* (work RVU = 23.35 and 130 minutes intra-service) is more intense, requires significantly more work and significantly more physician time to perform than 67039. Therefore, the RUC recommends directly crosswalking 67039 to 33202 *Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)* (work RVU=13.20 and 65 minutes intra-service time), as both services require similar work and intensity to perform and maintains the proper rank order among this family of services. **The RUC recommends a work RVU of 13.20 for CPT code 67039.**

67040 Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation

The RUC reviewed the survey results from 138 ophthalmologists and retina specialists and determined that the respondents overestimated the work required to perform this service. The key reference service 67113 *Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens* (work RVU = 23.35 and 130 minutes intra-service) is more intense, requires significantly more work and significantly more physician time to perform than 67040. Therefore, the RUC recommends directly crosswalking 67040 to 32666 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral* (work RVU=14.50 and 75 minutes intra-service time) as both services require similar work and intensity to perform and maintains the proper rank order among this family of services. The RUC noted that the survey respondents' median work RVU increment between 67039 and 67040 was 1.00 work RVUs. The RUC determined that an incremental difference of 1.30 between 67039 and 67040 supports the magnitude between these two services. **The RUC recommends a work RVU of 14.50 for CPT code 67040.**

67041 Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)

The RUC reviewed the survey results from 138 ophthalmologists and retina specialists and determined that the respondents overestimated the work required to perform this service. The key reference service 67113 *Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens* (work RVU = 23.35 and 130 minutes intra-service) is more intense, requires significantly more work and significantly more physician time to perform than 67041. The RUC noted that this service is more intense than 67036, 67039 and 67040. This service accounts for the more intense physician work to remove the scar tissue on the retina and peel off delicately without causing damage to the macula, which would result in central vision loss. Therefore, the RUC recommends directly crosswalking 67041 to 45160 *Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach* (work RVU=16.33 and 60 minutes intra-service time) as both services require the same physician intra-service time to perform and maintains the proper rank order among this family of services. **The RUC recommends a work RVU of 16.33 for CPT code 67041.**

67042 Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)

The RUC reviewed the survey results from 141 ophthalmologists and retina specialists and determined that the respondents overestimated the work required to perform this service. The key reference service 67113 *Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade,*

cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens (work RVU = 23.35 and 130 minutes intra-service) is more intense, requires significantly more work and significantly more physician time to perform than 67042. The RUC noted that this service is more intense than 67036, 67039 and 67040. This service accounts for the more intense physician work to remove the scar tissue on the retina and peel off delicately without causing damage to the macula, which would result in central vision loss. The specialty societies noted that the survey respondents indicated that the physician time required to perform this service is the same as 67041 and should be valued the same. The RUC recommends directly crosswalking 67042 to similar service 45160 *Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach* (work RVU=16.33 and 60 minutes intra-service time) as both services require the same physician intra-service time to perform and maintains the proper rank order among this family of services. **The RUC recommends a work RVU of 16.33 for CPT code 67042.**

67043 Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

The RUC reviewed the survey results from 105 ophthalmologists and retina specialists and determined that the respondents overestimated the work required to perform this service. The key reference service 67113 *Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens* (work RVU = 23.35 and 130 minutes intra-service) is more intense, requires significantly more work and significantly more physician time to perform than 67043. The RUC noted that this service is more intense than 67036, 67039 and 67040. This service accounts for the more intense physician work to remove the scar tissue on the retina and peel off delicately without causing damage to the macula, which would result in central vision loss. The RUC recommends directly crosswalking 67043 to similar service 44187 *Laparoscopy, surgical; ileostomy or jejunostomy, non-tube* (work RVU=17.40 and 75 minutes intra-service time) as both services require the same intra-service time and intensity to perform and maintains the proper rank order among this family of services. **The RUC recommends a work RVU of 17.40 for CPT code 67043.**

Practice Expense:

The RUC accepted the standard 090-day global direct practice expense inputs as approved by the Practice Expense Subcommittee.

Work Neutrality:

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

CT Angiography (Tab 12)

Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR)

Facilitation Committee #3

In the Final Rule for 2013, CMS identified CPT codes 72191 *CTA pelvis with and without contrast*, 74174 *CTA abdomen and pelvis with and without contrast*, and 74175

CTA abdomen with and without contrast, stating that there is an anomalous relationship between the time periods for these services. In April 2013, the RUC noted that the specialty societies proposed two distinct actions on these three codes. First, the pre-service and post-service times for the component codes, 72191 and 74175, should not be higher than the bundled code, 74174. The RUC agreed and recommended 5 minutes of pre-service time and 5 minutes of post-service time for both 72191 and 74175, so that they are identical to the pre- and post-service components of 74174. Secondly, the specialties noted that while the intra-service times are all identical, 30 minutes, the relativity among the current work RVUs for these three codes is appropriate. Thus, the specialty societies indicated a new survey for this family (72191, 74174 and 74175) was not necessary. The RUC disagreed, stating that while the relativity of the work values for these three codes may be appropriate, the intra-service time appears anomalous. CPT code 74174 requires review of two anatomical sites and should thus take some additional intra-service time for the physician to interpret and report the findings compared to the single body region codes. The RUC recommended interim values and times and recommended that these services be surveyed for physician work and that the direct practice expense inputs be reviewed for the October 2013 RUC meeting.

In October 2013, the RUC questioned whether or not supervision activities occur concurrently and if multiple sets of images can be reviewed simultaneously. The specialty confirmed that supervision is direct, thus, the radiologist must be immediately available and images must be individually reviewed. The RUC confirmed that measurement work is not automated, but rather, manually completed. Also, radiation exposure, dose and registry reporting must be dictated into the patient record and is not automated.

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

The RUC reviewed the survey results from 67 radiologists and determined that maintaining the current work RVU of 1.81, which is the survey 25th percentile, appropriately accounts for the physician work. The RUC recommends the following service period times: 5 minutes pre, 25 minutes intra, and 5 minutes post. The RUC reviewed key reference code 74177 *Computed tomography, abdomen and pelvis; with contrast material(s)* (work RVU=1.82) and determined that since these two services have the exact same physician time and intensity, they should be valued nearly identical. The RUC also reviewed MPC code 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU= 1.82) and determined that although 92004 requires more time, 72191 is a more intense procedure. To further support this value, the RUC reviewed MPC code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU=1.75) and agreed that since 72191 requires slightly more time, it should be valued higher. Lastly, there was consensus among the RUC that a work RVU of 1.81 maintains relativity across the visceral CT Angiography family. **The RUC recommends a work RVU of 1.81 for CPT code 72191.**

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

The RUC reviewed the survey results from 66 radiologists and determined that maintaining the current work RVU of 2.20 which is below the survey 25th percentile, is appropriate. The RUC recommends the following service period times: 5 minutes pre, 30 minutes intra, and 5 minutes post. The RUC reviewed key reference code 74183 (*Magnetic resonance (e.g., proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences*), (work RVU=2.26) and agreed that these services both require 30 minutes of intra-service time to perform and should be valued similarly. To further support this value, the RUC reviewed MPC code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.* (work RVU=2.00) and agreed that although 99233 requires more physician time, the intensity of the surveyed code is greater. The RUC also reviewed MPC 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.* (work RVU=2.43) and agreed that since this procedure requires more physician work and complexity, it should be valued higher. Lastly, the RUC agreed that a work RVU of 2.20 maintains appropriate rank order across the family of services. **The RUC recommends a work RVU of 2.20 for CPT code 74174.**

74175 Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing

The RUC reviewed the survey results from 63 radiologists and determined that maintaining the current work RVU of 1.90 and the survey 25th percentile overstated the physician work. The RUC recommends the following service period times: 5 minutes pre, 25 minutes intra, and 5 minutes post. The RUC determined that a work RVU of 1.82, a direct crosswalk to 74177 *Computed tomography, abdomen and pelvis; with contrast material(s)* (work RVU = 1.82), also with 5 minutes pre, 25 minutes intra, and 5 minutes post, is more appropriate. The RUC agreed that an increment above 72191 is necessary to account for the additional complexity and physician work associated with CTA of the abdomen where a greater number of organs and larger breadth of pathology must be considered. While both the specialty societies and the RUC agreed that an increment of 0.01 was on the low end, given the lack of stronger crosswalk codes, the RUC agreed that this value was appropriate. To further support this value, the RUC reviewed MPC code 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU= 1.82) and determined that physician work and intensity are similar. The RUC also reviewed CPT code 92616 *Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;* (work RVU=1.88) and agreed that this procedure requires more physician work and should therefore be valued higher.

Lastly, there was consensus among the RUC that a work RVU of 1.82 maintains relativity across the visceral CT Angiography family. **The RUC recommends a work RVU of 1.82 for CPT code 74175.**

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

The Practice Expense Subcommittee reviewed the direct practice expense inputs for the CT Angiography services and made the following modifications:

- Pre-service clinical activities was expanded to include "Availability of prior electronic images confirmed" with 2 minutes allocated to CPT codes 74175 and 72191 and 3 minutes to 74174;
- Time was reduced for "Review patient electronic clinical information and questionnaire reviewed, order from physician confirmed, and exam protocolled" from 5 minutes for CPT codes 74175 and 72191 to 2 minutes and from 7 minutes for CPT code 74174 to 3 minutes;
- Staff type for "greeting patient, providing gowning, ensuring appropriate medical records are available" was changed from a CT technologist to a radiologic technologist;
- Time was reduced for "Assisting physician in performing procedure/Computer post processing" from 49 minutes to 33 minutes for CPT code 74174;
- The following post service activities were added: technical quality control with 2 minutes allocated to 74175, 72191 and 74174; Review documents with physician with 2 minutes allocated to 74175, 72191 and 74174 and scanning documents into PACs with 1 minute allocated to 74175, 72191 and 74175;
- The following medical supply changes were made: computer media, optical disk 2.6gb was removed, 1 computer media, dvd was added, sodium chloride 0.9% flush syringe was removed, sodium chloride 0.9% inj (250-1000ml uou) was added, tube, extension (cm) was revised from 76 cm to 3 feet, drape, sterile, three quarter sheet was removed;
- Lastly, the following equipment changes were made: time for computer workstation, 3D reconstruction CT-MR was reduced for CPT code 74174 from 49 minutes to 33 minutes, CT room time was increased from 38 minutes to 40 minutes for CPT codes 74175 and 72191 and from 55 minutes to 57 minutes for CPT code 74174.

Ultrasound (Tab 13)

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

In April 2011, ultrasound services were identified through the CMS/Other codes with Medicare utilization over 500,000 screen. In January 2013, the specialty society submitted a request to crosswalk Ultrasound codes 76645 *Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation*, 76705 *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)*, and 76775 *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited*, to CPT code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation*. The RUC agreed that a crosswalk may be inappropriate for these high volume codes which

also include high intra service time. In addition, the current time of these codes are based on CMS/Other rather than RUC survey data; therefore, it would be difficult to validate. The RUC recommended that the specialty society use the standard survey methodology and present survey data and direct practice expense inputs at the October 2013 RUC meeting for CPT codes 76645, 76705, 76700, 76775, and 76856. In addition, CPT Code 76857 (*Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)*) was identified under the CMS/Other screen with the lowered Medicare utilization threshold of over 250,000.

The specialty societies presented compelling evidence for CPT code 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)*, which was accepted by the RUC. The specialty societies indicated that the methodology utilized by CMS to determine the original value was flawed. Data to support the original value, including a vignette is not available. In addition, the Diagnostic Ultrasound guidelines were revised in 2005 to clarify that all ultrasound examinations require permanent recorded images with measurement and require a full, written report be issued for inclusion in the patient's medical record, which has increased physician work. Lastly, the patient population has changed and now requires greater follow up of complicated ovarian cysts undertaken by ultrasound.

76645 Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation

The specialty society submitted a request to refer CPT code 76645 to the CPT Editorial Panel. At the October 2013 meeting, the CPT Editorial Panel deleted 76645 and created two codes to report limited and complete breast ultrasound procedures. **The RUC agreed and recommends that CPT code 76645 be referred to the CPT Editorial Panel for deletion.**

76700 Ultrasound, abdominal, real time with image documentation; complete

The RUC reviewed the survey results from 50 radiologists and determined that maintaining the current work RVU of 0.81 is appropriate. The RUC noted that both 76700 and 76705 (*Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses*) require 5 minutes of pre-time and 5 minutes of post-time, as both the complete and limited studies require the review of prior studies during the pre-service period and decision making and reporting of those comparisons during the post-service period. In addition, the intra-service time for 76700 is 11 minutes versus 8 minutes for 76705 due to the greater number of structures studied for 76700. To support this value, the RUC reviewed key reference code 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus* (work RVU=0.85) and CPT code 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU=0.99) and agreed that since these both require more physician time, they are appropriately valued higher. There was consensus among the RUC that a work RVU of 0.81 maintains relativity across this family of services. **The RUC recommends a work RVU of 0.81 for CPT code 76700.**

76705 Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)

The RUC reviewed the survey results from 50 radiologists and determined that maintaining the current work RVU of 0.59 is appropriate. The RUC noted that both 76700 and 76705 require 5 minutes of pre-time and 5 minutes of post-time, as both the complete and limited studies require the review of prior studies during the pre-service period and decision making and reporting of those comparisons during the post-service period. In addition, the intra-service time for 76700 is 11 minutes versus 8 minutes for 76705 due to the greater number of structures studied for 76700; the 8 minutes of intra-service time for the limited study is appropriate since the limited study involves the follow up of a specific condition in a specific organ, such as a mass in the liver, requiring careful assessment of interval change and careful consideration of follow up actions. To support this value, the RUC reviewed key reference code 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses* (work RVU=0.65) and agreed that although 76815 requires less physician time, it is a more intense procedure. The RUC also reviewed MPC code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU=0.56) and determined that the intra-service time for 76536 requires 2 more minutes than 76705, but the higher RVU for 76705 is appropriate given the greater intensity of abdominal pathology. There was consensus among the RUC that a work RVU of 0.59 maintains relativity across this family of services. **The RUC recommends a work RVU of 0.59 for CPT code 76705.**

76770 Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete

The RUC reviewed the survey results from 50 radiologists and determined that maintaining the current work RVU of 0.74 is appropriate. The RUC noted that both 76770 and 76775 (*Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited*) require 5 minutes of pre-time and 5 minutes of post-time, as both the complete and limited studies require the review of prior studies during the pre-service period and decision making and reporting of those comparisons during the post-service period. However, the intra-service time for 76770 is 2 minutes longer due to the greater number of structures studied. The RUC reviewed key reference code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU=0.75) and agreed these two services should be valued similarly since the physician time and intensity are comparable. The RUC also reviewed MPC code 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit* (work RVU=0.76) and determined that although the physician time is the same, 99231 is a slightly more intense service. There was consensus among the RUC that a work RVU of 0.74 maintains relativity across this family of services. **The RUC recommends a work RVU of 0.74 for CPT code 76770.**

76775 Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited

The RUC reviewed the survey results from 50 radiologists and determined that maintaining the current work RVU of 0.58 is appropriate. The RUC noted that both 76770 and 76775 require 5 minutes of pre-time and 5 minutes of post-time, as both the complete and limited studies require the review of prior studies during the pre-service period and decision making and reporting of those comparisons during the post-service period. However, the intra-service time for 76770 is 2 minutes longer due to the greater number of structures studied; the 8 minutes of intra-service time for 76775 is appropriate since the limited study involves the follow up of a specific condition in a specific organ, such as a mass in the kidney, requiring careful assessment of interval change and careful consideration of follow up actions. The RUC reviewed key reference 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 although 76536 requires more physician time, it is a less intense procedure. The RUC also reviewed MPC code 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses* (work RVU=0.65) and determined that although 76815 requires less time, it is a more intense procedure. There was consensus among the RUC that a work RVU of 0.58 maintains relativity across this family of services. **The RUC recommends a work RVU of 0.58 for CPT code 76775.**

76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete

The RUC reviewed the survey results from 50 radiologists and determined that maintaining the current work RVU of 0.69 is appropriate. The RUC noted that both 76856 and 76857 (*Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)*) require 5 minutes of pre-time and 5 minutes of post-time, as both the complete and limited studies require the review of prior studies during the pre-service period and decision making and reporting of those comparisons during the post-service period. However, the intra-service time for 76856 is 3 minutes longer due to the greater number of structures studied. The RUC reviewed key reference code 76830 *Ultrasound, transvaginal* (work RVU=0.69) and agreed that 76830 and 76856 both require 10 minutes of intra-service time to perform and therefore should be valued the same. The RUC also reviewed CPT code 76776 *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* (work RVU=0.76) and determined that although physician time is similar, 76776 is a more intense procedure. There was consensus among the RUC that a work RVU of 0.69 maintains relativity across this family of services. **The RUC recommends a work RVU of 0.69 for CPT code 76856.**

76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)

The RUC reviewed the survey results from 50 radiologists and determined that a work RVU of 0.50 is appropriate. The RUC noted that both 76856 and 76857 require 5 minutes of pre-time and 5 minutes of post-time, as both the complete and limited studies require the review of prior studies during the pre-service period and decision making and reporting of those comparisons during the post-service period. However, the intra-service time for 76856 is 3 minutes longer due to the greater number of structures studied; the 7 minutes of intra-service time for 76857 is appropriate since the limited study involves the follow up of a specific condition in a specific organ, such as a mass in the adnexa, requiring careful assessment of interval change and careful consideration of follow up

actions. The RUC reviewed key reference 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 since 76536 requires more physician time, it should be valued higher. The RUC also reviewed MPC code 93923 *Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)* (work RVU=0.45) and determined that 76857 is a more intense procedure, and therefore, should be valued higher. There was consensus among the RUC that a work RVU of 0.50 maintains relativity across this family of services. **The RUC recommends a work RVU of 0.50 for CPT code 76857.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs for the ultrasound services and made the following modifications:

- Pre-service clinical activities was expanded to include “Availability of prior electronic images confirmed” with 2 minutes allocated to CPT codes 76700, 76705, 76770, 76775, 76856 and “Review patient electronic clinical information and questionnaire reviewed, order from physician confirmed, and exam protocolled” was included with 2 minutes allocated to CPT codes 76700, 76705, 76770, 76775, 76856 and 76857;
- Time for “Greet patient, provide gowning, ensure appropriate medical records are available” was reduced to zero for CPT code 76857;
- Post service activities were expanded to include “Technical quality control” with 2 minutes allocated to 76700, 76770 and 76856 and 1 minute to 76705, 76775 and 76857; “Review documents with physician” was added with 2 minutes allocated to 76700, 76705, 76770, 76775, 76856 and 76857; Scanning other Documents into PACs was added with 1 minute allocated to 76700, 76705, 76770, 76775, 76856 and 76857;
- The Subcommittee removed “disinfectant, surface (Envirocide, Sanizide)” from medical supplies
- Ultrasound room time was reduced: 42 minutes to 33 minutes for CPT code 76700, 32 minutes to 23 minutes for CPT code 76705, 39 minutes to 30 minutes for CPT code 76770; 39 minutes to 30 minutes for CPT code 76856
- Ultrasound unit, portable was added with 23 minutes allocated to CPT code 76775 and 20 minutes to 76857

Electron Microscopy - PE Only (Tab 14) **Jonathan Myles, MD, FCAP (CAP)**

CPT Code 88348 *Electron microscopy; diagnostic* was identified by CMS through the Services with Stand-Alone PE Procedure Time screen and the RUC recommended that the RUC review the direct practice expense inputs at the October 2013 meeting. During the review of this family, it was determined that CPT code 88349 represents an

extraordinarily rare service. There were only 41 Medicare claims for 88349 in 2012. As a result, the specialty society concluded, and the RUC agreed that 88349 is an extremely limited clinical service which would be more appropriately reported as 88348. At the October 2013 meeting, the CPT Editorial Panel deleted CPT code 88349.

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made the following modifications in supplies: Nitrogen gas was reduced from 1 to 0.1; Glutaraldehyde was reduced from 5 to 1; Osmometer sample tip and cleaner was reduced from 3 to 1; Sodium acetate was deleted; Syringe 10-12 ml was reduced from 3 to 1; Syringe filter was reduced from 4 to 1; Safety glasses was deleted and all three spill kits were deleted. In addition the following equipment changes were made: vacuum deposition system, vacuum pump and Adobe software for digital printer were deleted and carbon coater was reduced from 60 to 22. Lastly, the Subcommittee confirmed that the line items for microscope, compound and microscope, binocular-dissecting are not duplicative. **The RUC recommends the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

X. Practice Expense Subcommittee (Tab 15)

Doctor Manaker, Chair, presented the report of the Practice Expense Subcommittee

Doctor Manaker thanked Doctor Neal for chairing the Moderate Sedation Monitoring Time Workgroup. The Workgroup has been examining the question of following recovery from moderate sedation, how much more patient monitoring time is needed. The Workgroup is currently collecting data from a multi-specialty coalition regarding the clinical necessity of both the mandatory clinical staff and the amount of time necessary for post-procedure monitoring, for services such as vascular access. The Workgroup will have one more call before the Holidays to review the available evidence to substantiate their requests. Data regarding the following items should be considered and articulated by the specialty societies:

1. The necessity for the clinical staff type to be RN rather than a blend for post-procedure following recovery from moderate sedation.
2. Relevant regulations from multiple states (2 or 3) which represent the typical scenario across the country.
3. Determination of whether or not the diameter of the access (size French) is correlated to the duration of the monitoring time.
4. Whether the use of a percutaneous closure device has an effect on the duration of the monitoring time.

The Practice Expense Subcommittee offers the following recommendations to the RUC:

- 1. The PE Subcommittee should continue to only dictate the staff type of RN for moderate sedation related inputs. The appropriate staff type for non-moderate sedation monitoring should be assessed on a code by code basis.**
- 2. A separate line should be created on the PE spreadsheet that separates out post-procedure moderate sedation as a distinct labor time PE input. In addition, another line should be created in the intra-service portion of the service period for an RN to administer moderate sedation.**

3. The standard time for post-procedure monitoring attributed to moderate sedation monitoring should be 1 hour (1:4 nurse/patient ratio – resulting in 15 minutes of clinical staff time (RN staff type). The maximum time for post-procedure monitoring, not related to moderate sedation, should be 1 hour (1:4 nurse/patient ratio – resulting in 15 minutes of clinical staff time (RN/LPN blend). This would make the maximum standard for post-procedure monitoring time 30 minutes. As with all standards, a specialty can propose compelling evidence to receive additional time.
4. The seven bronchoscopy codes (31625, 31626, 31628, 31629, 31634, 31645, and 31656) included in the review, which currently have non-standard monitoring time, should all be standardized to 15 minutes moderate sedation monitoring time, with 0 minutes of post-procedure monitoring time.

The Contrast Imaging Workgroup reviewed the standard supply package for CT and MRI codes with contrast enhanced imaging. The Workgroup finalized the standard package listed below and began using the package at this meeting. The Workgroup agreed to add to the IV Starter Kit an *underpad 2ft x 3ft (Chux)* (SB044). Finally, the PE Subcommittee and specialty societies agreed that this standard package would also extend to CT & MR angiography studies, with the addition of a stop cock (SC050) and additional tubing.

Imaging w/Contrast - Standard Package			
MEDICAL SUPPLIES	CODE	UNIT	QUANTITY
kit, iv starter	SA019	kit	1
gloves, non-sterile	SB022	pair	1
angiocatheter 14g-24g	SC001	item	1
heparin lock	SC012	item	1
iv tubing (extension)	SC019	foot	3
needle, 18-27g	SC029	item	1
syringe 20ml	SC053	item	1
sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068	item	1
swab-pad, alcohol	SJ053	item	1

Revisions to the IV Starter Kit – adding supply code (SB044) underpad 2ft x 3ft (Chux)

IV Starter Kit
1 tourniquet
1 alcohol prep pad
1 PVP ointment
1 PVP prep pad
2 gauze sponges (2"x2")
1 bandage (1"x3")
1 sm roll surgical tape
1 pr gloves
1 underpad 2ft x 3ft (Chux)

Lastly, Doctor Manaker updated the Practice Expense Subcommittee members on recent events surrounding CPT code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural*. In April 2013, the PE Subcommittee reviewed the non-facility practice expense inputs for 63650. However, the Subcommittee inadvertently assigned a quantity of two lead arrays for this procedure, which the CPT descriptor designates should be reported per array. These recommendations were forwarded to CMS in May. Shortly thereafter, the specialty societies were made known of this error and met with CMS directly to clear up the issue. With the Chair's approval, a revised PE spreadsheet correctly indicating one lead array was forwarded to CMS in September. The Practice Expense Subcommittee ratified the decision to submit amended PE inputs to CMS for CPT code 63650.

XI. Administrative Subcommittee (Tab 16)

Doctor Przybylski provided the Administrative Subcommittee report to the RUC. Doctor Przybylski indicated that the Subcommittee reviewed three topics to address issues of greater transparency.

I. RUC Member Review and Participation

After the April 2013 meeting, the American Academy of Dermatology (AAD) and the American Academy of Family Physicians (AAFP) requested further clarification regarding a RUC member's role when a specialty chooses to comment (LOI=2) on an issue under consideration. Doctor Levy referred this issue to the Administrative Subcommittee for review and discussion.

1. When assigning RUC members to review tabs, it is the RUC's established process to preclude RUC members from either the surveying or commenting specialty to be a reviewer of that issue. The Subcommittee appreciates that dermatology brought the error in assignment of the AAFP RUC member to the destruction of premalignant lesions issue to AMA Staff's attention prior to the RUC meeting. **The Subcommittee reaffirms its process for AMA staff not to assign "level 1" or "level 2" interested specialty societies' RUC members to review such tabs.**

2. The Subcommittee understood the AAFP argument that they were not attempting to advocate for the issue, that role lies with the specialty society Advisor. RUC leadership cannot understand what position a RUC member may take prior to the beginning of that discussion. The RUC Chair wants to ensure that all concerns about the resources utilized for a particular code be raised directly during the course of the RUC meeting. It is in the best interest of the RUC to resolve those concerns at the RUC meeting where presented. **The Administrative Subcommittee recommends that the metric to determine who may be "conflicted" to speak to an issue before the RUC be 1) if a specialty surveyed (LOI=1) or 2) submitted written comments (LOI=2).**

In further discussion, it was noted that the RUC reviewer comments mirrored the same comments of the specialty society that submitted written comments on an issue. **The Subcommittee recommends adding the following instruction to the primary reviewer instructions: "Specialty society staff or specialty society RUC Advisors should not be involved in developing primary reviewer comments on an issue. RUC Members and RUC Alternate Members should use their independent expertise to develop primary reviewer comments in response to specialty society recommendations."**

The Subcommittee also recommends that the RUC Chair welcome the RUC Advisor for any specialty society that submitted written comments (LOI=2), to come to the table to verbally address these written comments. It would be at the discretion of that society if they wish to sit at the table and provide further verbal comments.

II. RUC Transparency

RUC Meeting Attendance

Doctor Przybylski noted that information regarding RUC meeting dates and locations are already posted and assessable on the CPT web site, however the Subcommittee recommends that this information also be assessable on the RBRVS web site. **Therefore, the Subcommittee recommends posting the RUC meeting dates and locations to the AMA RBRVS web site (www.ama-assn.org/go/rbrvs).**

Publication of Minutes

Doctor Przybylski noted that the RUC minutes are made public after the Final Rule is public via inclusion in the RBRVS DataManager. AMA staff will begin publishing the total RUC vote per code after the November 2013, publication of the Final Rule for 2014. **The Administrative Subcommittee recommends that the RUC minutes be shared on the AMA RBRVS web site after the Final Rule is published each year.**

XII. HCPAC Review Board (Tab 17)

Doctor Mangold informed the RUC that the HCPAC had two agenda items.

I. Relative Value Recommendation for CPT 2015

The HCPAC reviewed CPT code 976XX1 *Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day* and will submit their recommendation of 0.35 work RVUs and slight modifications for the direct practice expense inputs for CPT code 976XX1 to CMS for CPT 2015.

Ultrasonic Wound Assessment

Timothy Tillo, DPM (APMA); Richard Rausch, PT (APTA)

The CPT Editorial Panel converted CPT Category III code 0183T to a Category I code to report low frequency ultrasound wound therapy (LFU). Since 2008, utilization and adoption by all multi-disciplinary specialties involved in wound care has significantly increased for LFU.

The HCPAC reviewed the survey results from 83 physical therapist and podiatrists. The health care professional organizations indicated that the survey respondents may have overestimated the intra-service time when comparing it to the key reference service 97597 *Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less* (work RVU=0.51 and 14 minutes intra-service time). The HCPAC agreed that the survey respondents may have compared the reference service, which accounts for debridement of a wound that is 20 sq cm, to a larger size wound typical for the surveyed service, thus indicating a higher intra-service time. APMA and APTA also indicated

that the median work RVU of 0.51 (same as the key reference service) and the survey 25th percentile work RVU of 0.49 were also then overestimated. The health care professional organizations recommended and the HCPAC agreed to directly crosswalk the work and time for 976XX1 to similar service 29582 *Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed* (work RVU = 0.35, pre-time= 4 minutes, intra-time= 12 minutes and post-time= 2 minutes). **The HCPAC recommends a work RVU of 0.35 for CPT code 976XX1.**

New Technology

The HCPAC also noted that this service represents the use of new technology and will be placed on the new technology list to re-examine and possibly resurvey after use of the technology has diffused.

Practice Expense

The PE Subcommittee reviewed and accepted the direct practice expense inputs with minor modifications.

II. Audiology on the RUC HCPAC

The HCPAC reviewed the AMA Proposal and with minor modifications recommends the following:

- 1. Due to the 2008 change in the Medicare statute allowing speech language pathologists to independently bill Medicare for their services, the RUC HCPAC should create a separate seat for speech language pathology, with a speech language pathologist RUC HCPAC Member and Alternate appointed by the American Speech-Language-Hearing Association (ASHA).**
- 2. Due to the substantial audiologist memberships in both ASHA and the American Academy of Audiology (AAA), it is appropriate that the audiology RUC HCPAC seat be shared by ASHA and AAA.**
 - a. AAA and ASHA should each appoint an audiologist to the audiology RUC HCPAC seat for a 3-year term.**
 - b. One audiologist will serve as the audiology RUC HCPAC Member and the other audiologist will serve as the audiology RUC HCPAC Alternate Member, rotating on an annual basis. AAA offered ASHA the first opportunity to appoint an audiology RUC HCPAC Member, with AAA appointing the RUC HCPAC Alternate Member for the first rotation.**
- 3. The RUC HCPAC amended the RUC HCPAC Organizational Structure and Processes document to accomplish this change. The HCPAC adopted the changes to the RUC HCPAC Organizational Structure and Processes by a two-thirds majority vote.**

XIII. Relativity Assessment Workgroup (Tab 18)

Doctor Raphaelson, Chair, gave the report for the Relativity Assessment Workgroup:

- 1. New Technology/New Services Review**

Doctor Raphaelson indicated that the Workgroup had reviewed action plans from the specialty societies for services identified via the new technology/new services list. **The Workgroup recommended:**

CPT Code	Workgroup Recommendation
14302	Review in 2 years (Oct 2015) with additional data per unit from CMS.
17106	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
17107	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
17108	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
31626	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
31627	Review practice expense January 2014. Review data again in 3 years (Sept 2016).
32553	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
43281	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
43282	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
43775	Remove from list, carrier priced.
46707	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
49411	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
53855	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
57425	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
57426	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
58541	Survey January 2014
58542	Survey January 2014
58543	Survey January 2014
58544	Survey January 2014
58570	Survey January 2014
58571	Survey January 2014
58572	Survey January 2014
58573	Survey January 2014
74261	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
74262	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
74263	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
75571	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
75572	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
75573	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
75574	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
78811	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
78812	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
78813	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
78814	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
78815	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
78816	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
88380	Survey January 2014 (added as part of 88381 family).
88381	Survey January 2014.

CPT Code	Workgroup Recommendation
88387	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
88388	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
94011	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
94012	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
94013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
95905	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

2. **Re-Review of Flagged Services**

Doctor Raphaelson indicated that the Workgroup reviewed action plans for 9 codes flagged to be re-reviewed after additional utilization data became available. **The Workgroup recommended:**

CPT Code	Workgroup Recommendation
10180	Remove from re-review. Specialties indicated that the service is appropriately valued in relation to 100XX1 recently reviewed by the RUC in January 2013. The specialties noted that the typical patient for 100XX1 could also be treated open with 10180. Also, the service described by 10180 will typically be performed with in the global period of another procedure.
36010	Remove from re-review, utilization dropped significantly.
36140	Remove from re-review. Utilization is dropping, coding guidelines have been implemented and current data reveals that this service is not typically reported with another CPT code.
37765	Review in 3 years (Sept 2016) after more data available.
37766	Review in 3 years (Sept 2016) after more data available.
68200	Remove from re-review. NCCI edit went into effect in 2012 and utilization is dropping.
71275	Survey for January 2014, RUC to define family of services at this meeting (tab 12 CT Angiography).
73218	Remove from re-review.
92270	Survey January 2014, define family.

During review of the above services, the Workgroup noted that codes 37765 and 37766 may fall out on the site of service screen. In February 2011, the RUC established policy that for site of service issues, three consecutive years of data indicating 50% or less inpatient each year is required appropriate in order to eliminate any annual fluctuations in the claims data.

The RUC policy is that AMA staff will re-run the site of service data based on 2010, 2011 and 2012 Medicare data for the RAW to review and discuss in January 2014.

3. **NPRM for 2014 Identified Services**

In the Proposed Rule for 2014, CMS identified 24 codes/9 families of services for possible review or further explanation. The Workgroup reviewed these requests and recommended:

CPT Code	Workgroup Recommendation	Code Family
77372 77373	<p>No further action. The RUC stated in its comment letter to CMS on the NPRM for 2014:</p> <p>The RUC agrees that there is no reason to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes and we agree that SRS and SBRT treatments are appropriately captured with CPT codes 77372 and 77373. These codes have been recently reviewed by the RUC, CPT code 77372 in April 2013 and CPT code 77373 in January 2013. As part of this review of direct PE inputs, all technologies (including robotic functionality) were included. In addition, equipment invoices for all these technologies were included with the RUC's submission to CMS. The price for the SRS system, CMS equipment code ER083, is the result of weighting six different treatment systems. As such, the direct PE inputs used to develop PE RVUs for CPT codes 77372 and 77373 accurately reflect the typical resources used when furnishing these services in the office setting and the RUC supports eliminating the G-codes. The RUC encourages CMS to accept the PE recommendations as submitted for CY 2014.</p>	
17311 17313	RUC reviewed April 2013. RUC recommendations submitted to CMS for CPT 2014.	
21800 22305 27193	Delete from CPT (multiple ways to report or report as Evaluation and Management service).	
33960 33961	Refer to CPT as the service and typical patient has changed. Submit CCP for Feb or May 2014 CPT meeting.	36822
47560 47562 47563	No further action needed. CMDs may have been looking at 2012 data where 47562 and 47563 were incorrectly ranked. These codes are in the correct rank order based on the 2013 Medicare Physician Payment Schedule.	
55845 55866	Survey for April 2014 codes 55840, 55842 and 55845 since Harvard Valued. Maintain 55866, recently reviewed in Oct 2009, and there is no evidence of a change in technology to perform this service.	55840 55842

CPT Code	Workgroup Recommendation	Code Family
64566	<p>Maintain. RUC valued physician work in 2010. Intra-service description of physician work is as follows:</p> <p>The patient is placed in a sitting or supine position and the posterior tibial nerve access site is located. The area is sterilized with an alcohol prep pad and topical lidocaine is applied. The physician opens the sterile needle electrode, holds the needle pointing cephalad, positions the electrode at a 60° angle to the skin and inserts the needle through the skin adjacent to the tibial nerve. After the physician inserts the needle, the lead wire is connected to the stimulator. The adhesive backing from the surface electrode is removed and placed it near the medial aspect of the heel bone on the same leg as the needle electrode insertion. The needle electrode clip is attached by depressing the plunger on the clip to expose the connection hook around the needle electrode and release. The stimulator is turned on by pressing and holding the power button for approximately 2 seconds. An audible tone will sound and symbols will appear on the screen. The test mode is entered by pressing and holding the test button for approximately 2 seconds. The default setting for the test mode is level 0. The current is slowly increased using the adjustment button, while observing the patient's foot for a response. The patient's response is generally a toe flex, or an extension of the entire foot. After observing this, reduce current setting by one level. Based upon patient response and comfort level, the final setting is entered. In case the toe flex or movement of the foot does not exist. The physician must press the stop button and reposition the needle slightly. Re-enter test mode following the preceding instructions. If repositioning the needle does not lead to a response, discard the needle and repeat the procedure on the other leg. The patient is instructed to rest for 30 minutes while the needle electrode remains in place. The physician leaves the room and is available for any questions by the clinical staff during the 30 minute treatment.</p>	
76942 20610	<p>CPT code 76942 already on agenda to survey for April 2014. The Workgroup recommends CMS to not adjust intra-service time until it receives the RUC recommendations for physician work and practice expense for CPT 2015. Regarding 76942 and 20610 performed together, data are lower than RUC threshold to bundle. However, a CCP to bundle these services has been submitted to CPT for review at the October 2013 meeting. Other CMS PE equipment change suggestions are consistent with PE Subcommittee recommendations.</p>	
76930	Maintain.	
76932	Maintain.	
76936	Maintain.	
76940	Maintain.	
76948	Maintain.	
76950	Referred to CPT. Included in CCP for October 2013 CPT meeting.	
76965	Maintain.	

The Workgroup determined that for codes 76930-76965 there was no evidence of improper incentives to furnish the ultrasound services. The Workgroup recommends further review of these CMS identified services is not necessary.

4. **Re-Review of Previous Screens (based on new data)****High Volume Growth**

Doctor Raphaelson indicated that the Workgroup re-ran the High Volume Growth screen. The Workgroup reviewed action plans from specialty societies for these services identified. **The Workgroup recommends:**

CPT Code	Workgroup Recommendation	Code Family
11980	Resurvey physician work and PE for January 2014.	
17110	Remove from screen, growth is appropriate. The rise in utilization from 2006 to 2007 was solely due to the shift of all benign lesion destructions previously coded in the 1700X code series to the 1711X code series.	
17111	Remove from screen, growth is appropriate. The rise in utilization from 2006 to 2007 was solely due to the shift of all benign lesion destructions previously coded in the 1700X code series to the 1711X code series.	
22558	Remove from screen. Utilization has appropriately increased due to coding education for anterior lumbar discectomy and fusion using only code 22558. Previously, physicians may have been inappropriately reporting anterior lumbar corpectomy (63090). Utilization of 63090 has been gradually decreasing over the same time period where there has been growth of 22558.	
27370	Survey for January 2014	
29200	Survey for January 2014	29260, 29280
29240	Survey for January 2014	
29520	Survey for January 2014	
29530	Survey for January 2014	
31620	Survey for January 2014	
36475	Survey for January 2014	36476
36478	Survey for January 2014	
36479	Survey for January 2014	
64412	Survey for April 2014	
64416	Remove from screen, clinically appropriate after April 2008 RUC revaluation.	
64448	Remove from screen, clinically appropriate after April 2008 RUC revaluation.	
64561	Survey for January 2014.	
69401	Survey for January 2014, unless prefer to refer to CPT to define the service “with or without ear-popper”.	69400 69405
70100	Submit letter to CMS specifying the inappropriate reporting of this service with the hand-held device in Texas.	
70310	Submit letter to CMS specifying the inappropriate reporting of this service with the hand-held device in Texas.	
70496	Survey January 2014, specialty society to define family based on discussion at this meeting (tab 12)	
76819	Remove from screen. Increase in utilization of this code is the product of an increased number of beneficiaries covered by the Medicare program who have access to this important prenatal study.	

CPT Code	Workgroup Recommendation	Code Family
77421	Referred to CPT October 2013, already included in CCP.	
88356	Survey for April 2014	
92526	Review utilization in 3 years (Sept 2016)	
92610	Review utilization in 3 years (Sept 2016)	
92626	Refer to CPT Assistant to address specifically how to be used for the typical Medicare recipient. Review in 3 years (Sept 2016)	
92973	Introductory language and educational efforts were conducted. Review utilization in 3 years (Sept 2016).	
93613	Review utilization in 3 years (Sept 2016). Collect data under new bundled codes.	
93990	Survey for January 2014	
95251	Survey for January 2014	95250
95971	Survey for January 2014	
95972	Survey for January 2014	
96103	Refer to CPT to develop a new code to describe brief behavioral screening processes.	
96120	Refer to CPT to develop a new code to describe brief behavioral screening processes.	
97016	Maintain; entire PM&R code section under revision.	
97532	Maintain; entire PM&R code section under revision.	
97542	Maintain; entire PM&R code section under revision.	
97605	Survey for January 2014	
97606	Survey for January 2014	

CMS/Other

The Workgroup also reviewed action plans for CMS/Other source codes with 2011 Medicare utilization of 250,000 or more, which results in 42 services, 13 of which have already been identified and will be addressed in CPT 2014 and 10 of which are currently G codes. The Workgroup requested that the specialty societies submit an action plan for the October 2013 meeting for services not reviewed in the last 3 years or are not in the process of review. **The Workgroup recommends:**

CPT Code	Workgroup Recommendation	Code Family
70486	Survey for January 2014. Never RUC reviewed, but frequently reported.	
71100	Survey for January 2014. Never RUC reviewed, but frequently reported	
72070	Survey for January 2014. Never RUC reviewed, but frequently reported	
73060	Survey for January 2014. Never RUC reviewed, but frequently reported	
73520	Survey with future bundle CCP (<i>Identified by Joint CPT/RUC WG</i>)	
73565	Survey for January 2014. Never RUC reviewed, but frequently reported	
73590	Survey for January 2014. Never RUC reviewed, but frequently reported	
73600	Survey for January 2014. Never RUC reviewed, but frequently reported	
74230	Survey for January 2014. Never RUC reviewed, but frequently reported	92611
75978	Survey for January 2014. Never RUC reviewed, but frequently reported	

CPT Code	Workgroup Recommendation	Code Family
76857	On October 2013 meeting agenda to be surveyed.	
88346	Survey for September 2014. Never RUC reviewed, but frequently reported	88347
92543	Survey for January 2014. Never RUC reviewed, but frequently reported	
93325	Survey for January 2014. Never RUC reviewed, but frequently reported	93320, 93321
93978	Survey for January 2014. Never RUC reviewed, but frequently reported	93979
99183	Survey for January 2014. Never RUC reviewed, but frequently reported	
G0101	Table until January 2014 and review with similar existing Category I code.	
G0179	Table until January 2014 and review with similar existing Category I code.	
G0180	Table until January 2014 and review with similar existing Category I code.	
G0181	Table until January 2014 and review with similar existing Category I code.	
G0202	Table until January 2014 and review with similar existing Category I code.	
G0204	Table until January 2014 and review with similar existing Category I code.	
G0206	Table until January 2014 and review with similar existing Category I code.	
G0283	Maintain; entire PM&R code section under revision.	
G0438	Table until January 2014 and review with similar existing Category I code.	
G0439	Table until January 2014 and review with similar existing Category I code.	

Services Surveyed by One Specialty – Now Performed by a Different Specialty

The Workgroup also re-examined the dominant specialties for services surveyed by one specialty and now performed by a different specialty based on 2011 Medicare utilization, which resulted in the identification of two services. The Workgroup reviewed action plans from the specialty societies for CPT codes 96103 and 96372. **The Workgroup recommended that CPT code 96103 be referred to the CPT Editorial Panel to develop a new code to describe brief behavioral screening processes and CPT code 96372 be removed from the screen since the specialty societies currently performing this service indicated the service is currently valued appropriately.**

5. Utilization Review (CPT 2011)

AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2011 cycle. There was one code that was not work neutral. The specialty societies predicted that with the creation of new CPT code 57156, the utilization would be split 50/50 for 57155 and 57156. However, the utilization split was 37/63 for 2011 and 29/71 for 2012. CPT code 57155 originally described multiple tandems and was changed to describe one tandem. The growth in utilization is most likely caused by code 57155 now typically reported in 2 units. Also, 57155 was previously a 090-day global and is now a 000-day global therefore there are additional visits associated with this service that are now reported separately.

Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy (57155 & 57156)

CPT Code	Long Descriptor	Work RVU
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	5.40
• 57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	2.69

The Workgroup requests that the specialty societies submit an action plan to explain why the estimated utilization and actual utilization are so different, and whether further RUC action is necessary.

New Technology Codes

In performing this utilization review, there were three 3 codes (64566, 88363 and 92132) that had high growth. The RUC placed 64566 and 92132 on the new technology list and will be reviewed by the Workgroup at the September 2014 meeting. AMA staff questions if 88363 should have been flagged as new technology. **The specialty societies indicated and the Workgroup agreed that it is appropriate to place 88363 on the new technology list.**

6. **Additional Screens**

In April 2013, the Relativity Assessment Workgroup had a robust discussion regarding additional proactive screens (Pre-time Package Analysis, Post-Operative Visits, and two Conscious Sedation screens) that may be reviewed to identify potentially misvalued services. **The Workgroup recommended tabling review of these screens to examine in more detail at the January 2014 Workgroup meeting.**

Comparison of Total Time to Total Work

Sherry Smith provided the RUC with review of total time to total RVU analysis. In 2009 Doctor Rich had provided this data and AMA staff re-ran the Medicare data for 2013. The conclusions in 2009 were that Evaluation and Management and Surgery intensity per unit of time were very similar. The findings again demonstrated that the total intensity work per unit of time is very similar for Surgery, Radiology and Evaluation and Management, however, is somewhat lower for Pathology and Medicine services. Also there has been an increase in intensity over all services. Finally, that E/M comprises a larger percent of total work and practice expense in the Medicare Physician Payment Schedule as demonstrated in the table below. The total number of minutes in Medicare Payment schedule was 50% and is now 52% and total work RVU related to E/M was 53% and is now 55%. E/M as a share of overall RVUs has significantly increased in the last several years, noting that this is after the E/M increases from the Third Five-Year Review.

Key Findings:

- Recently, there has been extensive discussion among stakeholders regarding perceived work value differences between cognitive and procedural services. However, the data shows that E/M services have a work RVU per minute significantly higher than pathology and medicine codes, and slightly below radiology and surgery services.
- Relative to other categories, E/M saw a large increase in total minutes and work RVUs as a percentage of the total. The HCPCS II codes also saw a large bump in these categories mainly due to CMS's creation of the Annual Wellness Visit and expanding payment for other preventative G codes.
- Overall, the work RVU per minute is up 4% over the last four years. The 2013 work RVU per unit of time increased slightly in all categories, except the CPT Category II codes.

Comparison of Total Time in the MFS to Total Work											
CPT Category	CPT Code Range	Total 2009 MFS Minutes (in millions)*	2009 Minutes % of Total	Total 2009 Work RVUs (in millions)*	2009 Work RVUs % of Total	2009 Work RVU per minute	Total 2013 MFS Minutes (in millions)**	2013 Minutes % of Total	Total 2013 Work RVUs (in millions)**	2013 Work RVUs % of Total	2013 Work RVU per minute
Surgery	10021 – 69990	5,882	19.46%	234	21.01%	0.0398	5,874	19.24%	242	20.56%	0.0412
Radiology	70010 – 79999	2,201	7.28%	87	7.81%	0.0395	1,933	6.33%	79	6.71%	0.0409
Pathology	80048 – 89356	794	2.63%	22	1.97%	0.0277	882	2.89%	26	2.21%	0.0295
Medicine	90281 – 99199	6,219	20.57%	173	15.53%	0.0278	5,395	17.67%	167	14.19%	0.0310
E/M	99201 – 99499	15,072	49.86%	590	52.96%	0.0391	15,940	52.21%	644	54.72%	0.0404
HCPCS 2 Codes	G, M, Q CMS Codes	59	0.20%	8	0.72%	0.1356	509	1.67%	19	1.61%	0.0373
	Total	30,227	100%	1,114	100%	0.0369	30,533	100%	1,177	100%	0.0385

* 2009 total time and work RVUs, 2007 estimated Medicare utilization data

** 2013 total time and work RVUs, 2012 estimated Medicare utilization data

XIV. Research Subcommittee (Tab 19)

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

The RUC reviewed and accepted the June and September conference call reports.

The Research Subcommittee discussed a referral to transition to a common survey administration tool to address concerns of policymakers and media about data collection methods and to ensure that the RUC survey data is collected and processed in a consistent manner. Currently, the AMA uses an online survey tool designed and approved by the Research Subcommittee in 2011 and licensed through the AMA's preferred survey vendor, Qualtrics. This survey tool is provided to the specialties and HCPAC organizations at no cost. The Subcommittee members discussed the merits of having one standard survey tool that would provide consistency in both the collection and processing of data for the Summary of Recommendation (SOR) forms.

The Qualtrics survey tool can be used on a voluntary basis by all specialty societies. While there is currently no mechanism to automatically calculate the data needed for the

SOR, the AMA is committed to investing resources to enhance the survey tool and provide an automated feature for calculating the inputs from raw data. Furthermore, the AMA is willing to provide ample staff support to ensure that the surveys are properly maintained and administered and that specialty staff is empowered to maintain a similar level of autonomy as they currently enjoy. Working with the Research Subcommittee, the AMA would also invest in programming to ensure that the reported survey data is computed using appropriate standardization and methodology.

It is important to note that the specialty society staff will continue to develop the survey sample, administer the survey and have access to the raw data for additional analysis apart from the questions on the SOR. The role for specialty society staff and consultants will not fundamentally change and they will be just as actively engaged as they are today. The AMA would provide additional assistance to the staff as they utilize the Qualtrics (or any future) survey tool. The Subcommittee noted that to date, thirteen specialty societies have used Qualtrics.

Several members expressed concern that the data not be warehoused by the AMA and/or released to the public. In addition, the anonymity of survey respondents is critical to this process. The AMA follows the CASRO Code of Standards and Ethics (<http://www.casro.org/?page=TheCASROCode>) which ensures the legal protection of survey respondents and data protection. The AMA has no intention to warehouse data collected from the RUC survey process. The Qualtrics system would allow specialty societies to lock their data from outside users. Therefore, AMA staff would only have access to the surveys or the raw data if it is granted. Specialties may find it necessary to have AMA staff assist them in survey development or address questions that arise while the surveys are live, but again permission would have to be granted for assistance to occur and/or for data to be released. Specialties would control the filing of the raw data at the completion of the survey. The data can remain on the “cloud” under the Qualtrics system or be downloaded and then deleted from the “cloud”. The Research Subcommittee members also discussed potentially contracting with a third party to provide data escrow services to attest that surveys were appropriately completed, and to maintain data in a secure, protected environment.

The Research Subcommittee recommends that the RUC transition to a centralized survey system. During the transition period, the Research Subcommittee will review and improve the survey and reporting systems.

The Research Subcommittee considered a referral to revise the respondent threshold to correspond with utilization data. The minimum threshold of 30 respondents has received significant criticism from policymakers and the media. The threshold of 30 was developed with input from consultants and statisticians based on the central limit theorem which states the distribution of means will increasingly approximate a normal distribution as the size of a sample (N) increases. At the time that this standard was developed, the RUC was considering only new CPT codes, which typically described new technology. However, the more recent focus on addressing misvalued codes has resulted in the review of established services, sometimes with high utilization.

AMA staff reviewed 1,477 codes surveyed by specialty societies and presented to the RUC between 2007-2013 and notes that typically more than 30 respondents are collected in the survey process (Mean=57; Median=46). A query outlined below reflecting CPT code, number of respondents and volume of previous RUC recommendations was

collated and was considered by the Subcommittee. These data demonstrate that the RUC could increase the number of expected responses for higher volume codes, without adding an undue burden to the specialty societies. Only 17.6% of all codes reviewed by the RUC have significant volume (ie, >100,000 Medicare claims). Only 514 of all CPT codes have Medicare volume greater than 100,000. A new minimum threshold for high volume codes will address criticism surrounding the appearance of low sample sizes, without significantly burdening the societies collecting data.

The Research Subcommittee considered the following proposed thresholds which were reviewed with AMA economists:

	Codes with ≥1 million Medicare Claims	Codes ≥ 250,000 Medicare Claims	Codes ≥ 100,000 Medicare Claims	Codes with <100,000 Medicare
# of Codes in MFS (n=6,888)	136 (2%)	312 (5%)	514 (7%)	6,374 (93%)
# of Codes Reviewed by RUC 2007-2013 (n=1,477)	71 (5%)	156 (11%)	260 (18%)	1,217 (82%)
Mean Number of Survey Respondents	88	83	75	53
Median Number of Survey Respondents	67	65	63	43
Proposed Threshold	50(or 75)	50	50	30
Percentage that met proposed threshold	73% (or 44%)	70%	63%	85%

As requested, AMA staff also reviewed 462 records of codes with less than 1,000 Medicare claims and found that 26% did not meet the current respondent threshold of 30. However, 85% of those records had at least 25 respondents. The RUC has historically reviewed data for very low volume codes with an understanding that few physicians may perform them, and therefore flexibility with the number of respondents is reasonable for these services.

The Research Subcommittee recommends that the following guideline thresholds be established:

- Codes with ≥1 million Medicare Claims = **75 respondents**
- Codes Medicare Claims between 100,000-1 million = **50 respondents**

- Codes with <100,000 Medicare = **30 respondents**

The Research Subcommittee discussed whether or not the survey instrument should be revised to include a length of stay question. The RUC has historically approved a visit on the same day as surgery, if the survey results demonstrate that a visit to the patient's bedside is typical on the same day/evening as surgery.

- The result is there may sometimes be more visits listed in the global period than the length of stay.
- CMS has speculated that the number of visits should mirror the length of stay. In the context of the 23+ hour stay discussion, the RUC added subsequent inpatient hospital visits and then later when subsequent observation days were created they added subsequent observation days. CMS did not allow the inclusion of this visit. However, the Agency allowed the intra-service time to be included and its value (time x .0224) was added to the immediate post-service period.

AMA staff clarified that, in regard to the issue of more visits than the length of stay, the RUC acknowledged that for some major surgical procedures, physicians would return the same evening to round on the patient. This is not duplicative, it just happens to be on the day of surgery. Patients admitted for medical reasons may be visited by the same physician more than once per day. In these situations, the physician is able to code a higher level hospital visit for the day to capture all of the time/work performed. The recognition of only .0224 RVUs of intensity for this same day visit does not capture the same level of intensity as hospital visits.

The Research Subcommittee noted that the survey instrument does capture whether or not a visit on the same day of surgery was made. **The Research Subcommittee recommends the continued use of the current survey instrument which appropriately captures post-operative visits, including those on the day of surgery.**

The Research Subcommittee discussed a referral to consider excluding low volume codes on Reference Service Lists. Currently, specialty societies are instructed to adhere to the following guidelines for RSL development:

- Include a broad range of services (i.e. 10-20 services) and their work RVUs. Select a set of references for use in the survey that is not so narrow that it would appear to compromise the objectivity of the survey result by influencing the respondent's evaluation of a service
- Include codes that represent services on the list which are well understood and commonly provided by physicians in the specialty or subspecialty. Accordingly, a specialty society's reference service list may vary based on the new/revised code being surveyed
- Include similar or related codes from the same family or CPT section as the new/revised code (For example, if you are surveying minimally invasive procedures such as laparoscopic surgery, include other minimally invasive services.)
- Include codes from the MPC list, if appropriate
- Include RUC validated codes
- Include codes with the same global period as the new/revised code
- Include several high volume codes typically performed by the specialty, if appropriate.

The Research Subcommittee members noted other concerns with RSLs, not just low volume codes (i.e., codes not recently reviewed, codes outside of family, etc). The Subcommittee members suggested adding a bullet point instructing specialty societies to seek approval from the Research Subcommittee if they cannot adhere to all the guidelines above. Other rules could be established to determine which RSLs would need to be approved by the Subcommittee. **The Research Subcommittee will consider enhancements to the guidelines and development of instructions for required RSL review at the January 2014 meeting**

XV. Post Time Workgroup (Tab 20)

Doctor Przybylski, Chair, provided the report to the RUC

At the October 2012 RUC meeting, it was suggested that the RUC review and consider standardization of immediate post service time for 0, 10 and 90 day global codes similar to standard pre-service packages. The standard packages do not apply to codes with a ZZZ or XXX global period. A workgroup was developed and charged with presenting a recommendation on standardized immediate post time to the RUC.

Immediate Post-Service Time includes "non-skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit, and communicating with the patient, family and other professionals (including written and telephone reports and orders).

The Post Time Workgroup met via conference call on July 24, 2013 to continue discussion from the April 2013 RUC regarding the standardization of immediate post service time. The Workgroup determined that the RUC continue to assign post-time based on survey data for non-facility procedures without the development of packages. However, for all facility based procedures, the Workgroup identified the following post-service activities and discussed time as follows. The Workgroup members agreed that these packages are to be used as guidelines for determining post time; however, post time should never exceed survey data unless the specialty society can provide sufficient justification.

- Dressing: 2 minutes
- Operative note: 5 minutes
- Recovering/Stabilization of patient:
 - Local: 1 minute
 - IV Sedation: 5 minutes
 - General Anesthesia: 10 minutes
- Communication with patient/family: 5 minutes
- Written post-op note:
 - Simple procedure: 2 minutes
 - Complex procedure: 5 minutes
- Repositioning/Transfer of Patient: 1 minute

Therefore, based on the above, the RUC approved six post time packages. Please refer to the attached post-time packages worksheet for more detailed information:

- Local/Simple
- Local/Complex

- IV Sedation/Simple
- IV Sedation/Complex
- General Anesthesia/Simple
- General Anesthesia/Complex

The Workgroup continued to discuss the post time packages at the October 2013 RUC meeting and agreed that the recommendations outlined above are appropriate. The Workgroup recommended that specialty societies utilize the post time packages above beginning with the January 2014 RUC meeting.

The Post Time Workgroup also reviewed pre-time packages relating to local anesthesia. In the 2013 Final Rule CMS requested that the RUC consider assigning services that require only local anesthesia without sedation to the “no sedation/anesthesia care” pre-service time package, or that the AMA RUC create one or more new pre-service time packages to reflect the pre-service time typically involved in furnishing local anesthesia without sedation.

At the April RUC meeting, the Post-Time Workgroup members reviewed pre-service time packages and determined that procedures that require only local anesthesia should be assigned to packages 1A and 2A when performed in the facility. The Workgroup noted that package 5 currently does not have time allocated for local anesthesia. However, it was noted that package 6 included 5 minutes for the administration of local anesthesia.

The workgroup members continued to discuss pre-time packages and concluded that package 5 should have 1 minute allocated for the administration of local anesthesia and package 6 should have 5 minutes for the administration of moderate sedation. The pre-service time packages worksheet has been revised to reflect these changes and is attached for your review.

In addition, the Workgroup members reviewed and discussed a request to add Dorsal Lithotomy to the Pre-Service time packages with a total time of 5 minutes. This positioning time applies to Urology (e.g. cysto codes), OBGYN (e.g. incontinence procedures), General Surgery (e.g. rectal procedures) and Radiation Oncology (e.g. prostate seed implants). The Workgroup members agreed that 5 minutes for Dorsal Lithotomy is appropriate. The pre-service time packages worksheet has been revised to reflect this additional positioning time.

XVI. BETOS Workgroup (Tab 21)

The Chair of the BETOS Workgroup, Doctor Chad Rubin, was unavailable to give the report so Doctor Geraldine McGinty provided a summary of the Workgroup’s actions to the RUC.

The BETOS Workgroup primarily accomplished two things at this meeting. First, the Workgroup members approved the specialty societies’ changes as well as the re-classification of codes currently designated as Ambulatory. These changes will be given to the specialty societies for review prior to submission to CMS. As part of this clean up, the members also agreed to recommend that several unique BETOS classifications that CMS does not currently use but are widely used by outside researchers be added to the

official BETOS classification list. Second, the Workgroup laid out their next steps for further improvements to BETOS.

- 1) Engage in discussions with CMS, MedPAC and/or other stakeholders who use and analyze BETOS classifications to determine how they use this information and what improvements they feel should be made.
- 2) Continued discussion about major and minor procedures will occur. AMA staff will gather several elements of data (e.g. work RVU, global, physician time, IWPUT and type and number of post-operative visits), merge them together and determine if natural groupings begin to form to help determine a set of guidelines to better categorize procedures in either major or minor. Following the creation of these general guidelines, they will be provided to the specialties to assist them in their review.
- 3) The current BETOS classifications, including the workgroup’s recommended changes, will again be forwarded to specialty societies for them to review and provide further recommendations.

XVII. MPC Workgroup (Tab 22)

The Chair of the MPC Workgroup, Doctor George Williams, provided a summary of the Workgroup’s actions taken at this meeting.

The MPC Workgroup members reviewed proposals from several specialties for codes to be added to the MPC list. Representatives from three specialty societies (ACR, AUA, ACS) attended the meeting to provide clarity and answer questions from workgroup members. **The MPC Workgroup recommends that the following CPT codes be added the MPC list moving forward:**

CPT	Long Descriptor
23350	Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography
37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
47562	Laparoscopy, surgical; cholecystectomy
49505	Repair initial inguinal hernia, age 5 years or older; reducible
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated
50590	Lithotripsy, extracorporeal shock wave
51705	Change of cystostomy tube; simple
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

CPT	Long Descriptor
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
54530	Orchiectomy, radical, for tumor; inguinal approach
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
57288	Sling operation for stress incontinence (eg, fascia or synthetic)
60500	Parathyroidectomy or exploration of parathyroid(s);
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
74176	Computed tomography, abdomen and pelvis; without contrast material
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions
74280	Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon
76830	Ultrasound, transvaginal

XVIII. Global Period Workgroup (Tab 23)

The Chair of the Global Period Workgroup, Doctor J. Allan Tucker, provided a summary of the Workgroup's actions taken at this meeting.

In response to CMS officials' questioning the appropriateness of having a visit on the same day as surgery and whether this visit should be included in the valuation for these procedures at the April 2013 RUC meeting, Doctor Levy created this workgroup to review the issue of global periods in general. The Workgroup was charged with

considering if the RUC should pursue any global period changes and/or conduct a review of services reported within a global bundle. The Workgroup discussed two separate global period revisions that could achieve the goal of ensuring the accurate payment of services provided in the post-operative period of a given service. First, a 090 day global service could be reduced to 000. Second, 090 day global service(s) could be reduced to a 010 day global. Rather than creating screens, the Workgroup recommended that specialty societies be queried to bring forward codes, if necessary, that may benefit from a change in global period. **The RUC had no additional discussion related to this matter and the Workgroup will move forward with querying specialties this summer.**

XIX. Other Business

A RUC Member brought up an inconsistency in the intensity value that is attributed to documentation of work (written report) in the intra-service time versus the post-service time. Many RUC members contributed to the discussion, noting that, regardless of where the reporting is captured and the value, if it is consistent across the family of codes, relativity will be maintained.

A RUC advisor spoke on behalf of Pediatrics about survey data and respondent issues. The Advisor suggested that the Evaluation and Management survey should be reviewed. The Advisor praised the work of the Research Subcommittee in improving sample size and centralizing the survey tool, but suggested that survey expertise was needed. The Chair clarified that the motion that came out of the Research Subcommittee already allocates resources for these improvements.

A RUC member asked if CMS' use of reverse building block is considered a flawed methodology under the guidelines of compelling evidence. The Chair clarified that the RUC has already formally commented to CMS that it is a flawed methodology.

The Committee discussed potential solutions to deal with reference service lists if the CMS' physician fee schedule final rule is delayed because of the government shutdown. The Chair of the Research Subcommittee suggested that conditional RSLs could be a way to deal with a late release date.

A RUC member was concerned about the use of documentation guidelines from CPT as compelling evidence. The Member noted that the CPT guidelines are meant to facilitate working with current technology. The Committee clarified that in certain circumstances it could be used as compelling evidence and that the RUC would have to consider the evidence on a code-by-code basis.

A RUC member requested that the rules regarding when moderate sedation is inherent (ie, 90%) be published in the RUC's instructions and functions.

RUC advisors representing Dermatology brought up that as a result of the new NCCI edits, evaluation and management was bundled into most of the minor procedure services. The Advisors stated that they thought this conflicted with RUC guidance of accounting for the overlap in pre-service time when an E/M is billed on the same day. RUC members clarified that the 25 modifier can be used when there is a significant and separately identifiable E/M service provided on the same date. The Advisors stated that result of the edits has been that private insurers are refusing to pay for evaluation and management if it occurs on the same day, even if it is for a separate diagnosis. RUC staff encouraged the

specialty to bring up the concerns to CMS if it is no longer typical that a separate E/M is performed on the same day.

Doctor Levy adjourned the meeting at 2:15pm on Saturday, October 5, 2013.