Application Submission Requirements

All CPT Code Change applications are reviewed and evaluated by CPT staff, the CPT/HCPAC Advisory Committee, and the CPT Editorial Panel. Strict conformance with the following is required for review of a code change application:

Submission of a complete application, including all necessary supporting documents;

- Adherence to all posted deadlines;
- Cooperation with requests from CPT staff and/or Editorial Panel members for clarification and information; and
- Compliance with CPT Lobbying Statement, (press “Ctrl” key and click link)

Application Review Links (Press “Ctrl” key and click link)

- Applicant’s Name
- Question 1
- Descriptor
- Typical Patient Description

Category II Specific Requirements

Criteria for Submitting CPT Category II Code Proposals

- Definition or purpose of the measure is consistent with its intended use (quality improvement and accountability, or solely quality improvement)
- Aspect of care measured is substantially influenced by physician work (or work of other practitioner or entity for which the code may be relevant)
- Reduces data collection burden on physicians (or other health practitioner or entity), reflects the work they perform, and is useful in physicians’ practice
- Significant
  - Affects a large segment of health care community
  - Tied to health outcomes
  - Addresses clinical conditions of high prevalence, high costs, high risks
- Evidence-based
  - Agreed upon
  - Definable
  - Measurable
- Risk adjustment specifications and instructions for all outcome measures submitted or compelling evidence as to why risk adjustment is not relevant
• Sufficiently detailed to make it useful for multiple purposes
• Facilitates reporting of performance measure(s)
• Inclusion of select patient history, testing (eg, glycohemoglobin), other process measures, cognitive or procedure services within CPT, or physiologic measures (eg, blood pressure) to support performance measurements
• Performance measure development process includes
  o Nationally recognized expert panel
  o Multidisciplinary
  o Vetting process

Definitions

Evidence-based practice is the integration of best research evidence with clinical expertise and patient values.

Best research evidence refers to clinically relevant research, often from the basic health and medical sciences, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination); the power of prognostic markers; and the efficacy and safety of therapeutic rehabilitative and preventive regimens.

Clinical expertise means the ability to use clinical skills and past experience to rapidly identify each patient’s unique health state and diagnosis, individual risks and benefits of potential interventions, and personal values and expectations.

Patient values refers to the unique preferences, concerns and expectations that each patient brings to a clinical encounter and that must be integrated into clinical decisions if they are to serve the patient.

American Medical Association
Department of CPT Editorial Research and Development
330 N. Wabash Ave., Suite 39300
Chicago, Illinois 60611-5885
or email ccpsubmit@ama-assn.org
Cover Sheet for CPT® Coding Change Application

It is recommended that applicants consult with national medical specialties and other qualified healthcare professional organizations that will typically provide the proposed procedure(s)/service(s) requested in this application to obtain comments on the type of work. With recognition of scheduling needs of the specialty societies, when assistance from a specialty society will be sought, it is highly recommended that the applicant plan for enough time for scheduling such discussions in advance of the application deadline to avoid violation of the AMA Lobbying Policy. Interested national specialty organizations may have deadlines prior to the CPT application submission deadline to allow for application review and comment.

Date:

Change Requested by:

Name(s):

Organization:

Address:

City: State: Zip Code:

Telephone:

Email:

Please include this cover sheet with your application.

Top ↑
NOTICE: Individuals or organizations that believe they may be affected by a decision of the CPT Editorial Panel on your code change application may request review of your application in advance of the CPT Editorial Panel meeting. To ensure transparency in the CPT Editorial Panel process, the AMA will provide your code change application and supporting documentation to such interested parties (provided they can demonstrate a valid interest) so they can be prepared, if desired, to comment at the CPT Editorial Panel meeting from the floor microphones or to submit written comments in advance of the meeting.

If the AMA receives a request from an interested party to review this code change application, you will be notified of that request and given five business days to submit a redacted version of the application that deletes any confidential and proprietary information. Failure to respond in that time will be deemed by the AMA as your approval to release the full application. The CPT Editorial Panel and CPT/HCPAC Advisory Committee will be provided the unredacted version of the application.

☐ Yes. I approve of sharing this application in full to an interested party that requests to review the application.

This form plays a vital role in maintaining and increasing the efficiency of the CPT process. It can be used to submit a coding change application for Category II CPT codes. For Category I, III, or Pathology and Molecular Pathology codes, please utilize the appropriate application form. As you fill out the form, please consider which category of code change you are requesting. For more information and code criteria for the code categories, please see the Code Change Application Instructions. For other forms, see the AMA CPT website.

(Press “Ctrl” key and click link)

When requesting a new code, the entire form should be completed. When submitting a request for multiple new codes, a response should be provided for each new code. The applicant may need to create additional lines and pages as needed. Refer to the Code Change Application Instructions if necessary. Once the application is completed, submit the form electronically to the AMA. (See information on submitting applications on the last page for instructions on uploading applications, literature supplements and other documents.)

You may withdraw your application up until the time that the CPT Editorial Panel takes up the agenda item at a CPT Editorial Panel meeting. At that time, the discussion falls under the authority of the Editorial Panel, and the application may not be withdrawn. If the CPT Editorial Panel determines that additional information or evaluation is warranted, consideration of your application may be tabled until later during that meeting or postponed until time certain (a specific future CPT meeting) or to time uncertain.
Specific Criteria Regarding the Measure

The following information is intended to help identify the important factors regarding the development process for measure for which the code(s) is(are) being developed.

Note: For specific information regarding developing the code descriptor, code location within the Category II code section, and the Alphabetical Clinical Topics Listing for the measure “snapshot” and code listing(s) (including the title of the Clinical Topic [or listing of the measure-code within an existing clinical topic], and the listing of the specific measure title), see the Specific Information for Development of the Category II code section.

In developing new and revised performance measurement codes, requests for Category II codes are considered from:

- Measurements that were developed and tested by a national organization;
- Evidenced-based measurements with established ties to health outcomes;
- Measurements that address clinical conditions of high prevalence, high risk or high cost;
- Well established measurements that are currently being used by large segments of the health care industry across the country;

In addition, the following criteria apply:

- Definition or purpose of the measure is consistent with its intended use (quality improvement and accountability, or solely quality improvement)
- Aspect of care measured is substantially influenced by physician work (or work of other practitioner or entity for which the code may be relevant)
- Reduces data collection burden on physicians (or other health practitioner or entity), reflects the work they perform, and is useful in physicians’ practice
- Significant
  - Affects a large segment of health care community
  - Tied to health outcomes
  - Addresses clinical conditions of high prevalence, high costs, high risks
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  - Definable
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- Risk adjustment specifications and instructions for all outcome measures submitted or compelling evidence as to why risk adjustment is not relevant
- Sufficiently detailed to make it useful for multiple purposes
- Facilitates reporting of performance measure(s)
- Inclusion of select patient history, testing (e.g., glycohemoglobin), other process measures, cognitive or procedure services within CPT, or physiologic measures (e.g., blood pressure) to support performance measurements
Performance measure development process includes

- Nationally recognized expert panel
- Multidisciplinary
- Vetting process

Note: These codes are not referred to the RUC for valuation because no RVUs are assigned to them. Since some of the Category II codes are services embedded within E/M codes, the aggregate service is already valued.

The measure from which the changes (i.e., codes, Alphabetical Clinical Topics Listing, and Category II Codes Section) are being made SHOULD BE PROVIDED AS PART OF THE APPLICATION. The application is considered incomplete without submission of the measures from which the changes are to be derived.

Development of the Alphabetical Clinical Topics Listing (found on the AMA website at https://www.ama-assn.org/sites/default/files/media-browser/public/cpt/cpt-cat2-codes-alpha-listing-clinical-topics_0.pdf)

This is an alphabetical listing of clinical conditions and topics with which the measures and codes are associated. It provides an overview of the performance measures, a listing of CPT Category II codes that may be used with each measure, as well as any applicable reporting instructions.

To view the entire Alphabetical Clinical Topics Listing (Alphabetical Listing), see the AMA website. (CPT Category II Codes Alphabetical Clinical Topics Listing (PDF))

The following questions are intended to assist in identifying the components that will be used to develop the listing that will be included in the Alphabetical Clinical Topics Listing.

### A. The definition or purpose of the measure is consistent with its intended use.

**A-1.** Identify the type of measure that is being used to develop each code(s). Choose from the following (select one category to define the purpose of your measure – e.g., PCPI Measure Designation: Type of measure.). If this application requests codes for multiple measure types, complete a separate application for each measure type:

**Composite Codes**

Composite codes combine several measures grouped within a single code descriptor to facilitate reporting for a clinical condition when all components are met. If only some of the components are met or if services are provided in addition to those included in the composite code, they may be reported individually using the corresponding CPT Category II codes for those services.

**Patient Management**

Patient management codes describe utilization measures or measures of patient care provided for specific clinical purposes (e.g., prenatal care, pre- and post-surgical care).

**Patient History**

Patient history codes describe measures for select aspects of patient history or review of systems.
A. The definition or purpose of the measure is consistent with its intended use.

<table>
<thead>
<tr>
<th><strong>Physical Examination</strong></th>
<th>Physical examination codes describe aspects of physical examination or clinical assessment.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic/Screening Processes or Results</strong></td>
<td>Diagnostic/screening processes or results codes describe results of tests ordered (clinical laboratory tests, radiological or other procedural examinations, and conclusions of medical decision-making).</td>
</tr>
<tr>
<td><strong>Therapeutic, Preventive, or Other Interventions</strong></td>
<td>Therapeutic, preventive, or other interventions codes describe pharmacologic, procedural, or behavioral therapies, including preventive services such as patient education and counseling.</td>
</tr>
<tr>
<td><strong>Follow-up or Other Outcomes</strong></td>
<td>Follow-up or other outcomes codes describe review and communication of test results to patients, patient satisfaction or experience with care, patient functional status, and patient morbidity and mortality.</td>
</tr>
<tr>
<td><strong>Patient Safety</strong></td>
<td>Patient safety codes that describe patient safety practices.</td>
</tr>
<tr>
<td><strong>Structural Measures</strong></td>
<td>Structural measures codes are used to identify measures that address the setting or system of the delivered care. These codes also address aspects of the capabilities of the organization or health care professional providing the care.</td>
</tr>
</tbody>
</table>

A-2. Provide the measure: List information for the measure here.

- **A.** Enter Clinical condition here (Clinical Topic – Use the topic listing identified in A-8)
- **B.** Enter the measure title here
- **C.** Enter a brief description of the measure
- **D.** Enter numerator statement from measure
- **E.** Enter denominator statement from measure
- **F.** Enter any relevant exclusions for this measure (medical, patient, or system)
A. The definition or purpose of the measure is consistent with its intended use.

G. Enter any reporting instructions needed for providing the service

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

The following includes an example language from an Alphabetical Clinical Topics Listing:

**Atrial Fibrillation and Atrial Flutter (AFIB)**

**Chronic Anticoagulation Therapy**
Whether or not the patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism was prescribed warfarin during the 12 month reporting period

**Numerator:** Patients who were prescribed warfarin during the 12 month reporting period

**Denominator:** All patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism

**Definitions of Risk**
Patients are identified by ACC/AHA/ESC 2006 guidelines at low risk for thromboembolism if there are none of the following factors: prior stroke or TIA, age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.

Patients are identified by ACC/AHA/ESC 2006 guidelines at intermediate risk for thromboembolism if there is one of the following factors: age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.

Patients are identified by ACC/AHA/ESC 2006 guidelines at high risk for thromboembolism if there is a prior stroke or TIA OR two or more of the following factors: age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.
A. The definition or purpose of the measure is consistent with its intended use.

<table>
<thead>
<tr>
<th>Exclusion(s): Documentation of medical reasons (eg, patients with transient or reversible causes of atrial fibrillation [eg, pneumonia or hyperthyroidism], postoperative patients, patients who are pregnant, allergy to warfarin, risk of bleeding) OR patient reason(s) (eg, economic, social, and/or religious impediments, noncompliance or other reason for refusal to take warfarin) for not prescribing warfarin</th>
<th>Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism who were prescribed warfarin during the 12 month reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Instructions: Report 3550F or 3551F or 3552F for each patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter. If the patient is classified as high risk for thromboembolism and warfarin therapy is prescribed, also report 4012F. For the patient with appropriate exclusion criteria, report 4012F with modifier 1P or 2P.</td>
<td>Warfarin therapy prescribed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3550F</td>
<td>Low risk for thromboembolism</td>
</tr>
<tr>
<td>3551F</td>
<td>Intermediate risk for thromboembolism</td>
</tr>
<tr>
<td>3552F</td>
<td>High risk for thromboembolism</td>
</tr>
</tbody>
</table>

A-3. Rationale for development of a code from the measure: Provide a rationale to describe how this measure will improve quality, accountability, better patient outcomes, etc.
| A. The definition or purpose of the measure is consistent with its intended use. |
| A-4. If the measure contains data elements useful for multiple purposes, describe the data elements. |
### Instructions for development of code descriptor and selection of code placement within the Category II Code Section

**A-5. Using the language that identifies the measure description, specify the new code(s) descriptor(s):**

**Instruction for Requesting a new Category II Code (addition of a code):**

Category II codes are listed within a particular subsection that most accurately represent the tracking of the clinician interaction with the patient (eg, **Patient History**, **Patient Management**, and **Physical Examination**).

Use the information provided in response to A-1 to identify the section that the code will be listed within. Include the code and descriptor using language that identifies the measure description.

**Example:**

**Category II**

**Physical Examination**

2010F  **Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed (CAP)\(^1\) (EM)\(^5\)**

- 200XF  New code language (New Acronym)

---

**Category II**

[Enter Existing Sub-Section Title here]

[Enter existing code(s) for placement]

● [Enter new code number and descriptor listing]
Using the language that identifies the measure description, specify the deleted code(s) descriptor(s):

Instruction for Requesting a Category II Code deletion:

Display the code selected for deletion and specify the recommended cross-reference (ie, how is the deleted service now to be coded?) Include the conventional technique of strike-outs for deletions. An example is listed for additional guidance.

Example:

Category II
Physical Examination

2002F  Clinical signs of volume overload (excess) assessed (HF)
2003F  Auscultation of the heart performed

(Code 2003F has been deleted. For performance measurement coding information regarding Heart Failure, see the Heart Failure Clinical Topic listing in Appendix H the Alphabetical Clinical Topics Listing)

Category II

[Enter Existing Sub-Section Title here (Response to question A-1)]

[Enter existing code(s) to show placement]

▲[Enter existing code listing with strike-through over the code and descriptor language to show the deletion]
A-7. **Using the language that identifies the measure description, specify the revised, code(s) descriptor(s):**

For each code requested, describe any specific code(s) that with modification might serve as a tracking code.

**Instruction for Requesting a Revised Category II Code:**

Specify the recommended terminology (code descriptor) for the proposed revised code. Use the conventional techniques of strike-outs for deletions and underlining for additions/revisions. Also, indicate the revision(s) in context with the current code descriptor (list the complete family of codes related to your request).

**EXAMPLE:**
Therapeutic, Preventive or Other Interventions

4006F  Beta-blocker therapy, prescribed \( \,/ \) (HF, CAD)

\( \, \) ▲4009F  Angiotensin converting enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy, recommended prescribed \( \,/ \) (HF, CAD)

**Category II**

[Enter Existing Sub-Section Title here]

[Enter existing code(s) for placement]

▲[Enter existing code number and descriptor listing with revisions here (use strike-through for desired deleted text and underline desired additional text)]
A-8. **Provide the Clinical Topic/condition/disease that this service is intended to address. This will be used to identify the Alphabetical Clinical Topics Listing that will be included for measure (this should be completed for each measure unless the measure may be included within a single topic).**

Choose a topic in which the measure listing and code will be placed within the Alphabetical Listing.

<table>
<thead>
<tr>
<th>Acute Bronchitis (A-BRONCH)</th>
<th>Eye Care (EC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)</td>
<td>Gastroesophageal Reflux Disease (GERD)</td>
</tr>
<tr>
<td>Amyotrophic Lateral Sclerosis (ALS)</td>
<td>Geriatrics (GER)</td>
</tr>
<tr>
<td>Anesthesiology/Critical Care (CRIT)</td>
<td>Heart Failure (HF)</td>
</tr>
<tr>
<td>Annual monitoring (AM)</td>
<td>Hematology (HEM)</td>
</tr>
<tr>
<td>Asthma</td>
<td>Hepatitis C (HEP C)</td>
</tr>
<tr>
<td>Atrial Fibrillation and Atrial Flutter (AFIB)</td>
<td>HIV/AIDS (HIV)</td>
</tr>
<tr>
<td>Back Pain (BP)</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Care for Older Adults (COA)</td>
<td>Inflammatory Bowel Disease (IBD)</td>
</tr>
<tr>
<td>Chronic Kidney Disease (CKD)</td>
<td>Lung Cancer/Esophageal Cancer (Lung/Esop Cx)</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Major Depressive Disorder (MDD)</td>
</tr>
<tr>
<td>Chronic Stable Coronary Artery Disease (CAD)</td>
<td>Major Depressive Disorder-Child and Adolescent (MDD ADOL)</td>
</tr>
<tr>
<td>Chronic Wound Care (CWC)</td>
<td>Melanoma (ML)</td>
</tr>
<tr>
<td>Community-Acquired Bacterial Pneumonia (CAP)</td>
<td>Nuclear Medicine (NUC_MED)</td>
</tr>
<tr>
<td>Coronary Artery Bypass Graft (CAGB)</td>
<td>Oncology (ONC)</td>
</tr>
<tr>
<td>Dementia (DEM)</td>
<td>Osteoarthritis (Adult) (OA)</td>
</tr>
<tr>
<td>Diabetes (DM)</td>
<td>Osteoporosis (OP)</td>
</tr>
<tr>
<td>Distal Symmetric Polyneuropathy (DSP)</td>
<td>Palliative/Endof Life Care (Pall Cr)</td>
</tr>
<tr>
<td>Emergency Medicine (EM)</td>
<td>Parkinson’s Disease (Prkns)</td>
</tr>
<tr>
<td>End Stage Renal Disease (ESRD)</td>
<td>Pathology (PATH)</td>
</tr>
<tr>
<td>Endoscopy and Polyp Surveillance (End/Polyp)</td>
<td>Pediatric Acute Gastroenteritis (PAG)</td>
</tr>
<tr>
<td>Epilepsy (EPI)</td>
<td>Pediatric End Stage Renal Disease (P-ESRD)</td>
</tr>
<tr>
<td></td>
<td>Pediatric Pharyngitis (PHAR)</td>
</tr>
</tbody>
</table>
### Existing Topic names and Codes to be Included

<table>
<thead>
<tr>
<th>Topic</th>
<th>Codes to be Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perioperative Care 2 (PERI 2)</td>
<td></td>
</tr>
<tr>
<td>Prenatal Care (Pre-Cr)</td>
<td></td>
</tr>
<tr>
<td>Prenatal-Postpartum Care (Prenatal)</td>
<td></td>
</tr>
<tr>
<td>Preventive Care &amp; Screening (PV)</td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer (PRCA)</td>
<td></td>
</tr>
<tr>
<td>Radiology (RAD)</td>
<td></td>
</tr>
<tr>
<td>Rheumatoid Arthritis (RA)</td>
<td></td>
</tr>
<tr>
<td>Screening Colonoscopy Adenoma Detection Rate (SCADR)</td>
<td></td>
</tr>
<tr>
<td>Stroke and Stroke Rehabilitation (STR)</td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorders (SUD)</td>
<td></td>
</tr>
<tr>
<td>Upper Respiratory Infection in Children (URI)</td>
<td></td>
</tr>
</tbody>
</table>

### Non-Measure Claims Based Reporting:

- Abdominal Aortic Aneurysm Repair
- Carotid Intervention

### A-9. List the clinical topic/disease/condition and the code that should be included within it.

If a new topic should be designated, include the name of the new topic and the acronym that will be used here.

**Existing Topic name:**

**Codes to be included:**

**New Topic name:**

**Codes to be included:**
B. The performance measure development process includes a nationally recognized expert panel with multidisciplinary representation and appropriate vetting.

B-1. Identify below the nationally recognized expert panel that developed the measure.

Footnotes

Physician Consortium for Performance Improvement, www.physicianconsortium.org
National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org
National Diabetes Quality Improvement Alliance (NDOIA), www.nationaldiabetesalliance.org
Joint measure from The Physician Consortium for Performance Improvement, www.physicianconsortium.org and National Committee on Quality Assurance (NCQA), www.ncqa.org
Ingenix, www.ingenix.com
American Academy of Neurology, www.aan.com/go/practice/quality/measurements Or quality@aan.com
American Gastroenterological Association (AGA), www.gastro.org/quality
American Society of Anesthesiologists, www.asahq.org
American College of Gastroenterology (ACG), www.gi.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org

If not represented above, provide name and any relevant information regarding the source of their authority for measure development (i.e., web site location where the measure may be found)

[Enter new society or name of measure developer here]

B-2. Describe the multidisciplinary review process used to achieve consensus on the measure among all constituents of the respective organizations, including internal and public comment processes.
C. The performance measure for which a tracking code is sought is not currently coded using existing code sets designated under HIPAA (eg, CPT Category I, ICD-9-CM, or HCPCS codes).

Describe how the testing for validity and feasibility for the measure was accomplished.

D. The performance measure development process includes a nationally recognized expert panel with multidisciplinary representation and appropriate vetting.

D. Describe any specific code(s) that with modification might serve as a tracking code.

See A-8

E. The aspect of care measured is substantially influenced by physician work (or work of other practitioner or entity for which the code may be relevant)

E-1. Identify the clinician (eg, specialty/subspecialty or qualified health care professional described by the new codes) for whom the code is relevant and why.
### E. The aspect of care measured is substantially influenced by physician work (or work of other practitioner or entity for which the code may be relevant)

**E-2.** Describe the services of the physician or QHP required to complete/affect the performance of the measure. Use the service(s) described in the measures Supporting Guideline[s]).

### F. The measure upon which this code is based is significant

**F-1.** Describe the relationship of the measure to the desired outcome (eg, PCPI: Measure Importance – Relationship to desired outcome)

**F-2.** Describe how the measure addresses clinical conditions of high prevalence, high costs, high risks?
### G. The measure is evidence-based.

**G-1.** Describe the evidence-base from which this measure was derived.

**G-2.** Describe the evidence-based process used for development of the measure.
<table>
<thead>
<tr>
<th>H. Risk adjustment instructions and specifications for outcome measures/ evidence of irrelevancy of risk adjustment.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H.</strong> Identify the patient for whom the measure would ordinarily apply but due to appropriate reasons (i.e., medical, patient, or system reasons) should be EXCLUDED from measurement (i.e., exclusions 1P, 2P, 3P).</td>
</tr>
</tbody>
</table>
Conflict of Interest Policy of Presenters

Every code change proposal applicant or his/her designee(s) making a presentation (“Presenter”) to the CPT® Editorial Panel on a code change application shall disclose all individual and corporate disclosable interests as defined below, but without regard to financial limit. Presenters who are applicants shall complete a written disclosure at the time of the code change application. Presenters who are a designee(s) of the code change proposal applicant shall complete a written disclosure in response to the “presenter letter” sent to applicants approximately two weeks in advance of the meeting of the CPT Editorial Panel. All Presenters are also asked by the Chair of the CPT Editorial Panel to make a verbal disclosure of individual and corporate interests at the time of presentation. Any disclosable interest that is a material individual interest or a material corporate interest must be designated as such in the disclosure.

CODE CHANGE APPLICATION APPLICANT OR DESIGNEE (“PRESENTER”)

DISCLOSURE OF INTEREST

I affirm that I have read and understand the Conflict of Interest Policy of the CPT Editorial Panel and Workgroup Members, Advisors and Presenters, a copy of which is available on the AMA CPT website. I have no individual or corporate disclosable interests at this time, except as set forth below. I understand that I have a continuing obligation to comply with the Conflict of Interest Policy and will update this form prior to any code change proposal application. Disclosure does not restrict or limit the ability of the presenter to support the applicant’s code change proposal.

<table>
<thead>
<tr>
<th>DISCLOSABLE INTERESTS</th>
<th>INDICATE IF MATERIAL INTEREST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Print Name
Signature
Date

Key Elements of Conflict of Interest Policy

For convenience, key elements of the Conflict of Interest Policy applicable for Applicants/ Presenters are summarized below. The Conflict of Interest Policy in its entirety is controlling (please refer to the
Conflict of Interest Policy in its entirety on the AMA CPT website: (press “Ctrl” key and click link)

- Presenters members must disclose all individual and corporate disclosable interests as defined in the Policy held by the member or immediate family without regard to financial limit.

- “Immediate family” means a spouse, domestic partner, parent, child, brother or sister of a Presenter. Requirements for disclosure of interests of immediate family apply to the extent such interests are known by the Presenter.

- “Disclosable individual interest” means cash, goods or other value (e.g., consultancies, speaking honoraria, salary or salary support, research or other grant support, stock ownership or options, expert testimony, royalties or other intellectual property rights, service on a speakers bureau, gifts, or paid travel and vacation) that, with respect to the Applicant/Presenter or the Applicant/Presenter’s immediate family members, the individual may receive such interest as a result of the approval or denial of the code change, the value of which exceeds $1.00 in the past two years.

- “Disclosable corporate interest” means cash, goods or other value (e.g., increased sales, decreased sales of competitors, increased value of intellectual property, increased grant support, etc.) which in the aggregate exceeds $5,000 within the past two years or is reasonably expected to exceed $5,000 in the next two years, only where the Presenter is a consultant, agent, or employee and the Presenter should reasonably be aware that their client or employer may receive such interest from the approval or denial of the code change proposal.

- Individual and corporate disclosable interests do not include [i] any interest that is limited to providing clinical services to patients (including the service for which a code change proposal has been submitted), or [ii] providing professional educational services or interpretative advice on proper coding.

- “Material individual interest” means a disclosable individual interest the value of which exceeds $10,000 in the aggregate within the past two years.

- “Material corporate interest” means disclosable corporate interest the value of which in the aggregate exceeds $10,000 within the past two years or is reasonably expected to exceed $10,000 in the next two years.

Presenters who are applicants shall complete a written disclosure at the time of the code change application. Presenters who are a designee(s) of the code change proposal applicant shall complete a written disclosure in response to the “presenter letter” sent to applicants approximately two weeks in advance of the meeting of the CPT Editorial Panel. All Presenters are also asked by the Chair of the CPT Editorial Panel to make a verbal disclosure of individual and corporate interests at the time of presentation.
**Statement on Lobbying**

Applicants and other interested parties must not engage in “lobbying” for or against code change applications. “Lobbying” means unsolicited communications of any kind made at any time (including during Editorial Panel meetings) for the purpose of attempting to influence either (1) the CPT Advisors’ evaluation of or comments upon a code change application or (2) voting by members of the Editorial Panel on a code change application. **Lobbying is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions such as being barred from further participation in the CPT process.** Information that accompanies a code change application, presentations or commentary to the full Editorial Panel during an open meeting and responses to inquiries from a Panel member or a CPT staff member do not constitute “lobbying.”

In order for the CPT Editorial Panel to effectively review and act on proposed changes to the CPT code set, code change applications must be reviewed by the CPT Advisors and the Editorial Panel based on the information contained in the application and available clinical literature. CPT staff is responsible for organizing and submitting information to the CPT Advisors and the Editorial Panel for consideration. Information relating to a code change application must be submitted to CPT staff no later than thirty days prior to the start of the Editorial Panel meeting at which the code change application will be considered. In some cases, the Chair of the Editorial Panel may establish rules which allow for supplemental submissions of information to workgroups or facilitation sessions established by the Chair or for postponed or appealed agenda items.

(A facilitation session is an informal meeting requested by the Chair during a CPT Editorial Panel meeting to allow interested parties to confer and attempt to reach a consensus recommendation for presentation at the meeting.) During development of a code change application, an applicant may seek input or assistance from staff or advisors of medical specialty societies but may not engage in “lobbying” as defined above. Medical specialty societies may have their own policies governing interactions with applicants or other interested parties regarding code change applications. The AMA encourages medical societies to work with applicants from both industry and other medical specialty societies to assure that code change applications are complete, coherent and consistent with current medical practice. Contacts with consulting medical societies should be limited to that which is necessary to construct and submit the code change application. After the date a code change application is posted for review and comment by the CPT Advisors and the Editorial Panel, contact between an applicant and medical society representatives should be confined to communications pertaining to feedback from the CPT staff or Advisors’ comments regarding the application. If an applicant or other interested party wishes the CPT Advisors or the Editorial Panel to consider additional information, that information must be submitted to AMA's CPT staff and not directly to the CPT Advisors or the Editorial Panel.

Applicants and other interested parties are invited to participate in open CPT Editorial Panel meetings and present their views on code change applications when recognized by the Chair during the course of the meeting. The views of applicants and other interested parties may be sought during work group or facilitation sessions established by the Chair and participation in a workgroup or a facilitation session is not considered lobbying.
Attestations

By signing below, I hereby attest to each of the following:

1) The information provided in this application is true, correct and complete, and, to the best of my knowledge, accurately depicts current clinical and or surgical practice;

2) I have read the CPT Statement on Lobbying, Criteria for Development and Evaluation of CPT Category I and Category III codes, CPT Code Application Instructions, CPT Editorial Panel Confidentiality Agreement, and CPT Application Process FAQs all referenced on the Applying for CPT Codes (press “Ctrl” key and click link) page and on related pages; and

3) I have authority to sign this application in both an individual and organizational capacity.

Copyright Assignment

In consideration of the American Medical Association’s review of this code change application, on behalf of myself and the organization names below, I hereby assign to the AMA all rights including copyright, if any, in the changes to the CPT code set contained in the application and any variation thereof approved by the CPT Editorial Panel.

Signature

Print Name

Organization (if applicable)

Date

AMA CPT Editorial Research and Development

Voice (312) 464-5486, fax (312) 224-6916

Instructions for Submitting your Code Change Application

Coding Change Application:

- Email the application and any signature pages to ccpsubmit@ama-assn.org.
• Only the Coding Change Application and any signature pages should be emailed to ccpsubmit@ama-assn.org.

Supporting documents for your Code Change Application should be uploaded to the AMA CPT Submissions page (https://connection.ama-assn.org/sites/CPT/Submit/default.aspx).

• You will be required to sign in to have access to this site.
• Any AMA website login account that you currently have (including your CPT Collaboration website username and password) should allow access to this site.
• If you do not have an AMA login account, press the link that says Create an Account on the login page in order to establish access to the AMA CPT Submissions site.

To use the drag and drop option for submissions of documents:

• The AMA CPT Submissions site is compatible with the following browsers: Internet Explorer, Chrome and Firefox. We have found that using Mozilla Firefox provides optimum performance. This browser can be obtained with a free download through the Mozilla website.

• Open the AMA CPT Submissions site using the link shown above. (Click the AMA CPT Submissions link or copy and paste the URL onto your browser address bar.)

• On the login screen, enter your username and password.

• Open the file on your computer that contains the documents to be uploaded.

• To make things easier, decrease the size of the window that you just opened as well as the size of the AMA CPT Submissions window. You may do this by clicking the icon that has the "2 overlapping boxes" located in the upper right hand corner of each page.

• Hold the Ctrl key down and highlight the files on your computer that you want to upload to the AMA CPT Submissions site.

• Place your cursor in this group of highlighted files, hold down the left button on your mouse and drag the documents from the source file directly to the AMA CPT Submissions site just below the heading Drop Off Library.

• When you see the notice Drop Here on the AMA CPT Submissions site, release the mouse button, and the files will transfer over. You will see the titles to the documents that you just submitted.

• If you decide to upload each document separately, press the “New Document” link. An “upload dialog box” will open allowing you to submit an individual document. These documents will not appear on the CPT Submission home page. They will be uploaded directly to the CPT staff site.

For security reasons, the files that you upload or drag and drop to the AMA CPT Submissions page will not be visible by any person other than you. Within approximately one hour, these items will be transferred to a different site that will allow the CPT Staff to review them.