AMA/Specialty Society RVS Update Committee
Rancho Bernardo Inn, San Diego, CA
January 10-13, 2018

Meeting Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Thursday, January 11, 2018 at 3:00 p.m. The following RUC Members were in attendance:

Peter K. Smith, MD
Margie C. Andreae, MD
Michael D. Bishop, MD
James Blankenship, MD
Robert Dale Blasier, MD
Ronald Burd, MD
Jimmy Clark, MD
Scott Collins, MD
Gregory DeMeo, MD
Verdi. J DiSesa, MD, MBA
David C. Han, MD
David F. Hitzeman, DO
Katharine Krol, MD
Timothy Laing, MD
Walter Larimore, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD, MACP
Alnoor Malick, MD
Scott Manaker, MD, PhD
Bradley Marple, MD
Julia M. Pillsbury, DO, FAAP
Gregory Przybylski, MD
Marc Raphaelson, MD
Christopher K. Senkowski, MD, FACS
Ezequiel Silva III, MD
Norman Smith, MD
Stanley W. Stead, MD, MBA
James C. Waldorf, MD
Jennifer L. Wiler, MD, MBA
George Williams, MD

Amr Abouleish, MD, MBA*
Allan Anderson, MD*
Gregory L. Barkley, MD*
Joseph Cleveland, MD*
William D. Donovan, MD, MPH*
Jeffrey P. Edelstein, MD*
William E. Fox, MD, FACP*
William F. Gee, MD*
Michael J. Gerardi, MD, FACEP*
Peter Hollmann, MD*
Gwenn V. Jackson, MD*
John Lanza, MD*
Mollie MacCormack, MD, FAAD*
Eileen Moynihan, MD*
Daniel J. Nagle, MD*
Scott D. Oates, MD*
M. Eugene Sherman, MD*
Holly Stanley, MD*
Michael J. Sutherland, MD, FACS*
Timothy H. Tillo, DPM*
Thomas J. Weida, MD*
Robert M. Zwolak, MD, PhD*

*Alternate

II. Chair's Report

- Doctor Smith welcomed everyone to the RUC Meeting.

- Doctor Smith welcomed the Centers for Medicare & Medicaid Services (CMS) staff and deferred introducing the CMS representatives to Doctor Hambrick during her report.

- Doctor Smith welcomed the following Contractor Medical Directors:
  - Charles Haley, MD, MS, FACP
  - Richard W. Whitten, MD

- Doctor Smith welcomed the following Members of the CPT Editorial Panel:
  - Kathy Krol, MD – CPT RUC Member
  - Jan Novak, MD – CPT Editorial Panel Member
  - Douglas C. Morrow, OD - CPT Editorial Panel Member

- Doctor Smith welcomed the following Observers:
  - Jack Resneck, Jr, MD – AMA Board of Trustees, Chair-Elect

- Doctor Smith wished a fond farewell to the following departing RUC Members:
  - Ronald Burd, MD - American Psychiatric Association (APA)
  - Timothy Laing, MD - American College of Rheumatology (ACRh)
  - Julia Pillsbury, DO, FAAP - Primary Care Rotating Seat

- Doctor Smith congratulated the following new or reappointed RUC Members:
  - Allan Anderson, MD - American Psychiatric Association (APA)
  - Verdi J. DiSesa, MD - Society of Thoracic Surgeons (STS)
  - Walter Larimore, MD - American Academy of Family Physicians (AAFP)
  - Alan E. Lazaroff, MD - American Geriatrics Society (AGS)
  - Marc Raphaelson, MD - American Academy of Neurology (AAN)
  - Jennifer L. Wiler, MD - American College of Emergency Physicians (ACEP)
  - George Williams, MD - American Academy of Ophthalmology (AAO)
  - Gregory Barkley, MD - American Academy of Neurology (AAN)
  - Joseph C. Cleveland, Jr, MD - Society of Thoracic Surgeons (STS)
  - Jeffrey Paul Edelstein, MD - American Academy of Ophthalmology (AAO)
  - Michael J. Gerardi, MD, FACEP - American College of Emergency Physicians (ACEP)
  - Gregory Harris, MD - American Psychiatric Association (APA)
  - Holly Stanley, MD - American Geriatrics Society (AGS)
  - Thomas Weida, MD - American Academy of Family Physicians (AAFP)

- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
  - Codes with $\geq$1 million Medicare claims = **75 respondents**
  - Codes with Medicare claims between 100,000-999,999 = **50 respondents**
  - Codes with <100,000 Medicare claims = **30 respondents**
  - Surveys below the established thresholds for services with Medicare claims greater than 100,000 will be reviewed as interim and specialty societies will need to resurvey for the next meeting.

- Doctor Smith conveyed the following guidelines related to confidentiality:
  - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement electronically prior to this meeting.)
  - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.

- Doctor Smith shared the following procedural rules for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
  - RUC members or alternates sitting at the table may not present or debate for their society.

  - RUC members or alternates should not attend Facilitations in which your specialty is involved (if you were assigned to that facilitation switch with another RUC member).
  - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.

- Doctor Smith laid out the following procedural guidelines related to specialty society staff/consultants:
  - Specialty Society Staff or Consultants should not present/speak to issues at the RUC Subcommittee, Workgroup or Facilitation meetings – other than providing a point of clarification.

- Doctor Smith conveyed the following procedural guidelines related to commenting specialty societies:
  - In October 2013, the RUC determined which members may be "conflicted" to speak to an issue before the RUC:
    1) a specialty surveyed (LOI=1) or
    2) a specialty submitted written comments (LOI=2).

    RUC members from these specialties are not assigned to review those tabs.
  - The RUC also recommended 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 their written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.

- Doctor Smith relayed the following procedural guideline related to presentations:
  - If RUC Advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC Chair.

- Doctor Smith shared the following procedural guidelines related to voting:
  - RUC votes are published annually on the AMA RBRVS website each July for the previous CPT cycle.
  - The RUC votes on every work RVU, including facilitation reports.
  - If members are going to abstain from voting because of a conflict or otherwise, please notify AMA staff so we may account for all 28 votes.
  - Please share voting remote with your alternate if you step away from the table to ensure 28 votes.

- Doctor Smith announced that all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.

- Doctor Smith conveyed the following information on the Analysis of RUC Recommendations based on a Crosswalk:
  - At the October 2017 meeting, the RUC referred a request to the Research Subcommittee to review the RUC's recent usage of crosswalk codes and whether further rules/ guidelines are necessary. The RUC requested for AMA staff to perform an analysis of previous RUC recommendations based on crosswalks.
  - Doctor Andreae, Research Subcommittee Chair, reported on the Subcommittee's review of crosswalk usage and its examination of data from the last two years. The Subcommittee determined that the current selection process for crosswalks, which takes into account multiple criteria including global period, RUC review, identical work RVUs and similar times, was reasonable and that defining a specific set of guidelines was unnecessary. It was noted that only about 1/5 of the codes result in a crosswalk to determine the value, most often via the facilitation committee process.

III. Director's Report

Sherry L. Smith, MS, CPA, Director of Physician Payment Policy and Systems, AMA provided the following information:

- Please use the Collaboration site to be sure you have all the handouts for the meeting and the revised practice expense spreadsheets.

- We encourage you to use the RUC meeting mobile app. The RUC meeting app is continuously updated to include which tab the RUC is discussing in the agenda (refresh from the home screen).

IV. Approval of Minutes from October 2017 RUC Meeting

- The RUC approved the October 2017 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

Doctor Krol provided the following update on the CPT Editorial Panel:

- Visiting Panel members at this RUC meeting are Jan A. Nowak, PhD, MD, and Douglas C. Morrow, OD, and CPT staff is Desiree Rozell.

- CPT/HCPAC Advisor Committee Annual Meeting
  The Annual Meeting will take place during the CPT Editorial Panel meeting on Thursday, February 8. Scheduled topics that may interest the RUC include: Digital Medicine Payment Advisory Group (DMPAG) update; technical review of procedure descriptions and clinical vignettes; and a discussion on technical component-only codes.

- CPT Editorial Panel Meeting Activity
  The Panel last met in September 2017 and an update was presented to the RUC at its October 2017 meeting. The Panel's next meeting is February 7-10, 2018 at Rancho Bernardo Inn. RUC member Michael Bishop, MD will attend the meeting as the RUC representative. Agenda items that may be of interest to the RUC are:

  - Revision of the abbreviated code change application, which is completed for code change requests that are prompted by RUC RAW screen results. The revision would be to update the list of RAW screens on the application to reflect the types of screens that currently exist.
  - The CPT Category I-III Literature Workgroup has submitted a request proposing clarification of literature requirements and instructions for code change requests. One particular item that will be addressed is clarification of literature requirements for proposed codes that describe *practice expense only*.
  - Codes on the February agenda that have been identified by RAW screens are codes 20005, 78492, 92225, 93561, 93562, and Long-term EEG codes.
  - Long-Term EEG Monitoring Services – Extensive work was invested by the Panel and various stakeholders regarding the long-term EEG Monitoring Services codes, at both the June and September Panel meetings. In September, the Panel postponed consideration of this request to time certain February 2018 to allow the applicants and interested stakeholders time to address questions by the Panel that need to be resolved, which pushes this issue into the next cycle.

  - The next application submission deadline is February 16, 2018 for the May Panel meeting.

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

Doctor Edith Hambrick, MD, JD, MPH, CMS Medical Officer, provided the report of the Centers for Medicare & Medicaid Services (CMS):

- Introduced staff from CMS attending this meeting:
  - Isadora Gil, PhD – Health Insurance Specialist
  - Karen Nakano, MD - Medical Officer
  - Michael Soracoe, PhD – Research Analyst
  - Marge Watchorn - Deputy Director, Division of Practitioner Services

- Since last Fall, there has been a management change for the Administration due to a resignation. Confirmation hearings for Mr. Alex Azar, the HHS Secretary-designate, are underway.

- CMS is working on the NPRM for the Medicare Physicians' Payment Schedule for CY2019. Please come in and talk to CMS about any issues regarding codes or policy proposals now.

VII. Contractor Medical Director Update (Informational)

Doctor Charles E. Haley, Medicare Contractor Medical Director, Noridian Healthcare Solutions, provided the Contractor Medical Director update:

- Jurisdiction J (AL, GA, TN) awarded its contract to Palmetto and that transition is underway. The transition will be complete in about two weeks and, at that point, there will be only seven claims-paying contractors from what used to be 64 twenty years ago. The number of Medicare Contract Medical Directors has remained the same (approx. 36). The list of CMDs can be found on the CMS website by searching MAC CMDs.

VIII. Relative Value Recommendations for *CPT 2019:*

<u>Fine Needle Aspiration (Tab 04)</u>
Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Andrew Moriarity, MD (SIR); Michael Hall, MD (SIR) and Curtis Anderson, MD, PhD (SIR)

CPT code 10021 was identified as part of the CMS OPPS/ASC cap payment proposal in the CMS Proposed Rule for CY2014. The proposal was to limit the practice expense payment through the physician payment schedule at the lower of two facility payment schedules, either the OPPS or ASC payment schedule. Although the CMS OPPS/ASC cap proposal was not implemented in the final rule for CY2014, the RUC forwarded a number of practice expense only recommendations for CY2015. In the CY2016 Medicare Physician Payment Schedule Final Rule, CMS noted concern about implementing practice expense inputs without the corresponding work being reviewed. The RUC identified CPT code 10021 as one of the services that CMS' request pertained to and requested that the specialties that perform this service submit recommendations for the January 2016 RUC meeting. CPT Code 10022 was identified under the CMS High Expenditure Procedure list in the NPRM for 2016. The specialty societies provided two reasons why these codes need to be referred to the CPT Editorial Panel prior to receiving a RUC survey. First, both codes need clarifying language stating that they should be reported per lesion rather than for every pass on the same lesion. Second, CPT code 10022 is reported with 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* more than 75% of the time together and a bundled code solution will be developed. In June 2017, the CPT Editorial Panel deleted one code, revised one code and created 9 new codes to describe fine needle aspiration procedures with and without imaging. At the October 2017 RUC

meeting, 10011 and 10012 did not meet the minimum survey threshold of 30 responses. The specialty society left the survey open and presented recommendations in January 2018. CPT code 77021 was identified as part of the family but was not surveyed for October, so the RUC recommended that it be surveyed for January 2018.

77021 ***Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation***
The RUC reviewed the survey results from 43 diagnostic and interventional radiologists and agreed with the following physician time component: pre-service evaluation time of 15 minutes, intra-service time of 45 minutes, and post-service time of 15 minutes.

The specialty society presented compelling evidence for CPT code 77021. The specialties noted that the patient population has changed since 77021 was last valued, pointing out that the utilization decreased when the guidance was bundled into new MR Guided breast biopsy codes. The specialty also noted potential miscoding for 77021 related to a service that involves using software to fuse pre-existing MR images with real-time ultrasound images of the prostate during a prostate biopsy. The specialty noted that the remaining correctly coded utilization was a more complex patient. The RUC noted that the typical patient used in the survey was the same typical patient that was used in 2000. The RUC did not approve the compelling evidence arguments made by the specialties.

The RUC determined the current work RVU of 1.50, which is below the survey 25th percentile, must remain givent he lack of compelling evidence. The RUC compared the survey code to CPT code 75710 *Angiography, extremity, unilateral, radiological supervision and interpretation* (work RVU= 1.75, intra-service time of 40 minutes, total time of 70 minutes) and noted that CPT code 77021 includes more intra-service time and total time, however it is slightly less intense to perform. **The RUC recommends maintaining the current RVU of 1.50 for CPT code 77021.**

10011 ***Fine needle aspiration biopsy, including MR guidance; first lesion***
The RUC recommends that CPT code 10011 to be carrier priced until the service is more widely utilized in the US. **The RUC recommends that CPT code 10011 be carrier priced.**

10012 ***Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)***
The RUC recommends that CPT code 10012 to be carrier priced until the service is more widely utilized in the US. **The RUC recommends that CPT code 10012 be carrier priced.**

Potential Miscoding for CPT code 77021
It was noted that there may be some miscoding for MR Guidance code 77021, where this code is inappropriately being reported for a service that involves using software to fuse pre-existing MR images with real-time ultrasound images of the prostate during a prostate biopsy. 42.3 percent of the global reporting for MR Guidance code 77021 is with ultrasound guidance code 76942 per 2015 billed together data. The specialty societies have already submitted an article to the CPT Assistant Board to clarify when to report this service.

Practice Expense
The RUC recommends the direct practice expense inputs without modification, as reviewed and approved by the PE Subcommittee.

New Technology/New Services
Codes 10011, 10012 and 77021 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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

Aortoventriculoplasty with Pulmonary Autograft (Tab 5)
James M. Levett, MD (STS); Stephen J. Lahey, MD (AATS) and Kirk R. Kanter, MD (STS)

In September 2017, the CPT Editorial Panel created one new code to combine the efforts of aortic valve and root replacement with subvalvular left ventricular outflow tract enlargement to allow for an unobstructed left ventricular outflow tract.

33440 ***Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)***
The RUC reviewed the survey results from 32 cardiothoracic surgeons and agreed with the following physician time components: pre-service time of 95 minutes, intra-service time of 300 minutes, immediate post-service time of 60 minutes, two critical care visits (99291), eight hospital visits (two 99231, three 99232, three 99233), one discharge (99238), and one office visit (99214), for a combined total of 998 minutes. The RUC did not accept the specialties initial presentation of the survey 75th percentile of 67.25 and determined that the survey median, a work RVU of 64.00, appropriately accounts for the physician work involved to perform this service. To justify the work RVU of 64.00, the RUC reviewed the top key reference service code 33622 *Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)* (work RVU= 64.00, pre-service time of 63 minutes, intra-service time of 300 minutes, immediate post-service time of 60 minutes, and total time of 986 minutes), and noted that both services require similar time and intensity and should be valued similarly.

To further justify a work RVU of 64.00, the RUC reviewed the second top key reference code 33863 *Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)*(work RVU= 58.79, pre-service time of 95 minutes, intra-service time of 287 minutes, and immediate post-service time of 40 minutes), and found that the surveyed code is appropriately valued higher because it requires more physician work, time, and is more intense and complex to perform as indicated by 100% of the survey respondents. **The RUC recommends a work RVU of 64.00 for CPT code 33440.**

Ross- Konno Procedure
The RUC discussed CPT codes 33412 *Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)* (work RVU= 59.00 and intra-service time of 300 minutes) and 33413 *Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)* (work RVU= 59.87 and intra-service time of 297 minutes). Both the Ross and Konno codes are rare procedures as they are performed infrequently and almost exclusively by pediatric heart surgeons. The RUC discussed why these codes were not surveyed with the surveyed combination procedure. The specialty society explained that the Ross and Konno services have not evolved since they were last reviewed by the RUC in 2010 and 2005, respectively and that they have not changed in technique or time required to perform the service. The RUC understands that all three codes (33412, 33413, and 33440) are performed 200 times collectively and that they are rarely performed.

Practice Expense
The RUC discussed that this service has 15 minutes more pre-service clinical staff time as is typical for many of the cardiothoracic srgery and neurosurgery services. The RUC recommends the direct practice expense inputs as reviewed and approved without modification by the PE Subcommittee.

New Technology/New Services
CPT code 33440 will be placed on the New Technology/New Services list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Do Not Use to Validate for Physician Work
The RUC agreed that CPT code 33440 should be labeled in the RUC database with a flag that it should not be used to validate physician work.

Hemi-Aortic Arch Replacement (Tab 6)
James M. Levett, MD (STS); Stephen J. Lahey, MD (AATS) and Kirk R. Kanter, MD (STS)

At the September 2017 CPT Editorial Panel meeting, the Panel created one new add-on code to report hemi-aortic arch graft replacement. Existing CPT codes 33860, 33863, 33864 and 33870 were identified as being part of the same family of services.

33866 ***Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 61 physicians and agreed with intra-service time of 165 minutes. The additional work that is involved with the aortic hemiarch replacement procedure is related to the additional time it takes to isolate the arch vessels, create means of establishing antegrade or retrograde cerebral protection/perfusion, cooling the patient for circulatory arrest, the time it takes to rewarm the patient, and the extra time it may take to obtain hemostasis at the end of the procedure. There are limits to how fast a patient can be rewarmed. During that period, the patients all have coagulopathy which makes it difficult to determine whether a patient has surgical bleeding. The RUC reviewed the recommended work RVU of 19.74, which is the 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 19.74, the RUC compared the survey code to top key reference code 33369 *Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)* (work RVU= 19.00, intra-service time of 160 minutes) and noted that the survey code involves somewhat more time and also that 94 percent of the survey respondents which selected this reference code rated the survey code as having more overall intensity and complexity. The RUC noted that this new add-on code was not surveyed along with its corresponding base codes. **The RUC recommends an interim work RVU of 19.74 for CPT code 33866.**

The RUC recommends that CPT codes 33860, 33863, 33864 and 33870 be surveyed as part of this family of services, as the RUC had last reviewed these services in the year 2010 (for 33860, 33863, 33864) and 2000 (for 33870). These codes, along with 33866 will be surveyed and presented at the April 2018 RUC meeting.

Referral to CPT Editorial Panel
The specialty noted that the work of CPT code 33866 hemi-aortic arch graft replacement may be incorrectly coded using CPT code 33870. The RUC observed that the current draft parenthetical following 33870 does not preclude 33870 from being coded with base codes 33860-33864 nor does it direct users to instead use 330X1 when hemi-aortic arch graft replacement is performed. **For CPT code 33870, the RUC recommends the CPT Editorial Panel consider the following parenthetical additions:**

(Do not report 33870 in conjunction with 33860, 33863, 33864 or 33866)

(Use +330X1 for work on the transverse aortic arch when performed in conjunction with 33860, 33863 or 33864)

Practice Expense
There are no direct practice expense inputs for CPT code 33866. This service is facility-only and does not require any clinical staff pre-service time.

New Technology/New Services
Codes 33866 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Leadless Pacemaker Procedures (Tab 7)
Mark Schoenfeld, MD (HRS); Richard Wright, MD (ACC); David Slotwiner, MD (HRS); Thad Waites, MD (ACC)

At the September 2017 CPT Editorial Panel meeting, the Panel replaced leadless pacemaker services Category III codes with the addition of two codes to report transcatheter leadless pacemaker procedures and revised five codes to include evaluation and interrogation services of leadless pacemaker systems.

33274 ***Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed***
The RUC reviewed the survey results from 90 cardiologists and agreed on the following physician time components: 33 minutes for pre-service evaluation time, 3 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 60 minutes for intra-service time, 20 minutes for immediate post-time, half-day discharge visit (99238) and 1, 99213 office visit. The RUC noted that the service typically involves an overnight stay that is less than 24 hours in length.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 8.77. To justify a work RVU of 8.77, the RUC compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23, intra-service time of 60 minutes, total time of 183 minutes) and noted that both services have identical intra-service time however, the surveyed code involves somewhat more intense physician work. **The RUC recommends a work RVU of 8.77 for CPT code 33274.**

33275 ***Transcatheter removal of permanent leadless pacemaker, right ventricular***
The RUC reviewed the survey results from 74 cardiologists and agreed on the following physician time components: 33 minutes for pre-service evaluation time, 3 minutes for pre-service positioning time, 15 minutes for pre-service scrub/dress/wait, 75 minutes for intra-service time, 20 minutes for immediate post-time, half-day discharge visit (99238) and 1 99213 office visit. The RUC noted that the service typically involves an overnight stay that is less than 24 hours in length. The specialties noted and the RUC agreed that it is appropriate for 33275 to have more time than 33274, as 33275 takes more time to perform. The specialties noted that this service is anticipated to be very low volume. Conventional thinking is that additional devices may be placed at the end of device life, and that removal would only occur when transitioning to a different therapeutic modality.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 9.56. To justify a work RVU of 9.56, the RUC compared the survey code to MPC code 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU= 9.23, intra-service time of 60 minutes, total time of 183 minutes) and noted that the survey code involves 15 more minutes of intra-time and slightly more total time, justifying a somewhat higher valuation relative to the reference code. **The RUC recommends a work RVU of 9.56 for CPT code 33275.**

Practice Expense
The PE Subcommittee changed the clinical activity CA036, *discharge day management* from 12 minutes to 6 minutes as the survey respondents indicated a half day discharge. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology/New Services
CPT code 33274 and 33275 will be placed on the New Technology/New Services list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 93279, 93286, 93288, 93294 and 93296. The relativity within the family remains correct.

Pulmonary Wireless Pressure Sensor Services (Tab 8)
Richard Wright, MD (ACC); Cliff Kavinsky, MD (SCAI); Thad Waites, MD (ACC); Sergio Bartakian, MD (SCAI)
Facilitation Committee #3

In September 2017, the CPT Editorial Panel created a code to describe pulmonary wireless sensor implantation and another code for remote care management of patients with an implantable, wireless pulmonary artery pressure sensor monitor.

33289 ***Transcatheter implantation of wireless pulmonary artery pressure sensor for long term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed***
The RUC reviewed the survey results from 33 cardiologists for CPT code 33289 and determined that the survey 25th percentile work RVU of 6.00 appropriately accounts for the work required to perform this service. CPT code 33289 is for the implantation of a wireless pulmonary artery pressure monitor through a catheter with pulmonary artery angiography. The device is indicated for patients who have been hospitalized for heart failure in the prior year. Once the artery pressure sensor is implanted and calibrated, patients transmit data daily that is interpreted and used to manage their care in a manner that avoids future hospitalization(s).

The RUC recommends 33 minutes evaluation time, 3 minutes positioning, 15 minutes scrub, dress, wait time, 40 minutes intra-service time and 20 minutes post-service time. The RUC compared 33289 to the top key reference service 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch* (work RVU = 10.96 and 76 minutes intra-service time) and noted that the survey respondents chose the key reference service because many cardiologists are familiar with intracoronary stents. The stenting is performed in the arterial circuit rather than the venous circuit. Therefore, the physician work is much less intense and complex for 33289, than deployment within the chest vessels.

The RUC compared 33289 to the second key reference service 93451 *Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed* (work RVU = 2.47 and 30 minutes intra-service time) and indicated that CPT code 93451 is the passage of the catheter into the pulmonary artery and then the measurement of hemodynamics. Whereas, for CPT code 33289 the pressure sensor device must be placed in a specific pulmonary artery branch where a pulmonary angiogram is performed to assess the size of the pulmonary artery in which the physician will deploy the pressure sensor. The physician must then calibrate the pressure against the sensor readings to make sure they are accurate. Therefore 33289 requires more physician time, work and is more intense and complex than CPT code 93451.

The RUC compared the surveyed service to similar service 93456 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization* (work RVU = 5.90 and 40 minutes intra-service time) and noted that the surveyed code requires slightly more pre- and post-service time to complete, therefore should be valued slightly higher. For additional support, the RUC referenced MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU = 6.75 and 45 minutes intra-service time). **The RUC recommends a work RVU of 6.00 for CPT code 33289.**

93264 ***Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional***
CPT code 93264 is the remote monitoring to interpret and document weekly downloads, of patient's daily transmissions, of the pulmonary artery pressure recordings over a 30 day period. The RUC reviewed the survey results from 54 cardiologists for CPT code 93264 and determined that the survey median work RVU of 0.80 was slightly high and the survey 25th percentile work RVU of 0.51 was too low compared to similar services. Therefore, the RUC recommends a crosswalk to MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70 and 2 minutes pre-time, 15 minutes intra-service time and 3 minutes post-service time). The RUC determined that the survey pre- and immediate post-service time seemed high and should be the same as the CPT code 95251. The RUC recommends 2 minutes pre-time, 13 minutes intra-service time and 3 minutes post-service time for CPT code 93264. The RUC determined that a work RVU of 0.70 for CPT code 93264 preserves the appropriate rank order with 99457 *Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month* (RUC recommended work RVU = 0.61) reviewed at this meeting, as 93264 is more intense and requires interpretation of more transmissions. The RUC also compared 93264 to similar service 99490 *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored* (work RVU = 0.61 and 15 minutes intra-service time) and noted that 93264 requires more total physician time, 18 versus 15 minutes, and more physician work than 99490.

For additional support the RUC referenced MPC code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU = 0.75 and 23 minutes total time) and similar service 11901 *Injection, intralesional; more than 7 lesions* (work RVU = 0.80 and 22 minutes total time). **The RUC recommends a work RVU of 0.70 for CPT ode 93264.**

Practice Expense
The Practice Expense Subcommittee made one minor revision and removed the equipment ED021 *computer, desktop, w-monitor* for CPT code 93264. The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.

New Technology/New Services
CPT codes 33289 and 93264 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

PICC Line Procedures (Tab 9)
Steve Krug, MD, FAAP (AAP) and David Kanter, MD, FAAP (AAP)

In the NPRM for the 2016 Medicare Physician Payment Schedule, CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010, and CPT code 36569 was identified. In October 2016, the RUC noted that CPT code 36569 is typically reported with CPT codes 76937 and 77001. These codes are commonly reported together because the current code contains a bimodal clinical scenario. The first scenario is when a clinical staff member performs the procedure without imaging. The second scenario is when a radiologist performs the procedure with imaging guidance. Therefore, CPT code 36569 was referred to the CPT Editorial Panel to have the two common imaging codes bundled into the code. The current coding language should remain for clinical staff, but a new bundled code should be created. The RUC recommended CPT code 36569 be referred to the CPT Editorial Panel and also codes 36568 and 36584 as part of the family. In September 2017, the CPT Editorial Panel revised codes 36568, 36569 and 36584 and created two new codes to specify the insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion.

Compelling Evidence
The specialty society presented compelling evidence for CPT codes 36568 and 36569. The society indicated that there has been a change in the providers of peripherally inserted central venous catheters (PICC). As facility-based PICC insertion has evolved, clinical staff PICC teams have assumed an increased role in non-image-guided PICC placement. The majority of trained PICC teams have evolved to include registered nurses or nurse practitioners, which have demonstrated a growing role for nursing in vascular access. This filtering of PICC procedures has delegated the more complex and challenging PICC placements to physicians and qualified healthcare professionals. This evolution of delegated PICC placement is reflected in increased physician time and work for CPT codes 36568 and 36569. Additionally, the society indicated that timing of PICCS placement has changed over time, possible complications in PICC placement with regard to infection and thrombi has made PICC procedures increasingly more complex in the neonatal setting. When central line access is required, there is less viable opportunity for easy vain access which ultimately makes PICC procedures more complicated in later stages. The specialty societies also noted that the patient population for CPT code 36568 has changed for neonates with gestational ages limits of viability down to 22-23 weeks and therefore are more challenging. Also, pediatricians were not involved in the previous survey. The RUC accepted that there is compelling evidence for CPT codes 36568 and 36569.

36568 ***Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age***
The RUC reviewed the survey results from 39 physicians and agreed with the following physician time component: pre-service time of 22 minutes, intra-service time of 38 minutes, and post-service time of 11 minutes, for a total of 71 minutes. The RUC reviewed the recommended work RVU of 2.11, which is the survey 25th percentile, and agreed that this value appropriately accounts for the physician work involved. The RUC noted that this service now requires 18 more minutes of intra-service time, therefore the increase in the work RVU is appropriate. To justify the work RVU of 2.11, the RUC reviewed similar services CPT code 51727 *Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique* (work RVU= 2.11, intra-service time of 35 minutes) and CPT code 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* (work RVU = 2.11, intra-service time of 40 minutes, and total time of 60 minutes), noting that these services require the same physician work and similar time. The RUC discussed the clinical intensity and complexity of PICC line procedures for with and without imaging codes. PICC line procedures take longer with pediatric patients and the derived intensity measure therefore appears lower. On the other hand, PICC line procedures for patients

over five years of age may be faster, but complexities are more intense for this population. **The RUC recommends a work RVU of 2.11 for CPT code 36568.**

36569 ***Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older***
The RUC reviewed the survey results from 32 physicians and agreed with the following physician time component: pre-service time of 22 minutes, intra-service time of 27 minutes, and post-service time of 11 minutes. The RUC reviewed the recommended work RVU of 1.90 which is the survey 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 1.90, the RUC reviewed CPT code 45327 *Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)* (work RVU = 1.90, and 28 minutes of intra-service time) and noted that both services require the same physician work and similar intra-service time. To further support a work value of 1.90 for the survey code, the RUC reviewed CPT code 32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance* (work RVU = 1.82, intra-service time of 20 minutes), and noted that the surveyed code requires more physician time to perform, thus appropriately valued higher. The RUC questioned the difference in work for the surveyed code compared to 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 1.75 and 15 minutes of intra-service time) and confirmed that 36556 is more intense and the complication risk to the patient is greater, however, the typical patient for 36569 are those not already treated by the PICC team, leaving the more challenging patients that take a lot more time. The RUC discussed the clinical intensity and complexity of PICC line procedures for with and without imaging codes. PICC line procedures take longer with pediatric patients and the derived intensity measure therefore appears lower. On the other hand, PICC line procedures for patients 5 years or older may be faster, but complexities are more intense for this population. **The RUC recommends a work RVU of 1.90 for CPT code 36569.**

36572 ***Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age***
The RUC reviewed the survey results from 46 physicians and agreed with the following physician time component: pre-service time of 19 minutes, intra-service time of 22 minutes, and post-service time of 10 minutes. CPT code 36572 describes insertion of PICC lines with imaging guidance for deeper veins such as the brachial or basilic veins that you can not see or feel, typically after a non-imaging PICC failed. The RUC reviewed the survey respondents' estimated physician work values and determined that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 2.39. The RUC recommends a direct crosswalk to CPT code 19283 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance* (work RVU = 2.00, intra-service time of 20 minutes) since both services require the same physician work and similar time to perform. The RUC also agreed that the survey code work RVU should parallel CPT code 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU = 2.00, intra-service time of 25 minutes), noting that code 49083 requires the same physician work and similar time as the surveyed code. The RUC discussed the clinical intensity and complexity of PICC line procedures for with and without imaging codes, noting that the with imaging PICC procedures are slightly easier due to the guidance assisting the physician to properly insert the PICC line. However, PICC procedures with imaging are conducted on deeper veins that can not be properly accessed without imaging. The RUC confirmed that since CPT code 36568 *Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age* (recommended work RVU = 2.11 and 38 minutes intra-service time) requires more physician time to complete than this service (38 versus 22 minutes intra-service time), the recommended work RVU of 2.00 for CPT code 36572 maintains the proper rank order within this family of services.

The RUC discussed reporting these services with chest x-rays and confirmed that the introductory language specifically states that "the physician or qualified healthcare professional reporting image-guided PICC insertion cannot report confirmation of catheter tip location separately (e.g., via X- ray,

ultrasound). Report 36572, 36573, or 36584 with modifier 52 when performed without confirmation of catheter tip location." **The RUC recommends a work RVU of 2.00 for CPT code 36572.**

36573 ***Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older***

The RUC reviewed the survey results from 64 physicians and agreed with the following physician time component: pre-service time of 19 minutes, intra-service time of 15 minutes, and post-service time of 6 minutes. CPT code 36572 describes insertion of PICC lines with imaging guidance for deeper veins such as the brachial or basilic veins that you cannot see or feel, typically after a non-imaging PICC failed. The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 2.25. The RUC recommends a direct crosswalk to CPT code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, intra-service time of 15 minutes), and noted that both services require the same physician work and similar time to perform. To further support the recommended work RVU of 1.90, the RUC reviewed CPT 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, intra-service time of 15 minutes), and noted that code 64483 involves identical intra-service time and similar total time as the surveyed code. The RUC discussed the clinical intensity and complexity of PICC line procedures for with and without imaging codes. The RUC specifically examined CPT code 36569 *Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older* (recommended work RVU = 1.90, intra-service time of 27 minutes) to the surveyed code that includes all imaging, and determined that the without imaging service is typically performed by a pediatrician and on palabale viewable veins, but requires more time to complete. Whereas, CPT code 36573 with imaging, is performed on patients that the without imaging insertion failed and requires almost half the time to complete. The RUC determined that 36569 and 36573 require the same physician work and should be valued the same, but 36573 is more intense. The RUC determined that in this case it would not be appropriate to value the CPT code 36573 less than the without imaging service because radiologists can perform the service more efficiently with imaging.

The RUC discussed reporting these services with chest x-rays and confirmed that the introductory language specifically states that "the physician or qualified healthcare professional reporting image-guided PICC insertion cannot report confirmation of catheter tip location separately (eg, via X- ray, ultrasound). Report 36572, 36573, or 36584 with modifier 52 when performed without confirmation of catheter tip location." **The RUC recommends a work RVU of 1.90 for CPT code 36573.**

36584 ***Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement***

The RUC reviewed the survey results from 64 physicians and agreed with the following physician time component: pre-service time of 17 total minutes, intra-service time of 12 minutes, and post-service time of 5 minutes. The RUC reviewed the recommended work RVU of 1.47, which is the survey 25th percentile, and agreed that this value appropriately accounts for the physician work involved. CPT code 36584 describes a PICC line replacement including all imaging for an existing PICC line that is malfunctioning or malpositioned. The existing PICC line is removed over a wire and using fluoroscopic guidance the wire and PICC line are navigated centrally. To justify the work RVU of 1.47, the RUC reviewed MPC codes 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands*

and feet); 7.6 cm to 12.5 cm (work RVU= 1.44, intra-service time of 17 minutes) and 52000 *Cystourethroscopy (separate procedure)* (work RVU = 1.53, intra-service time of 10 minutes) and noted that the work value and physician times of the survey code fall in between both MPC services, and should therefore be valued similarly. The RUC also agreed that code 27096 *Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed* (work RVU = 1.48, pre-service time of 17 minutes, intra-service time of 11 minutes, and post-service time of 10 minutes) supports the survey code recommended work RVU of 1.47. **The RUC recommends a work RVU of 1.47 for CPT code 36584.**

76937 ***Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)***
CPT Code 76937 is used by a variety of specialties for varying procedures and the utilization is expected to decrease when these new PICC procedures are bundled with the imaging modalities. At the January 2018 RUC meeting, the specialty societies proposed to review CPT code 76937 when two years of Medicare data (post-PICC bundling) becomes available. This will allow the specialty societies to develop a typical vignette and determine the specialties that need to be involved. **The RUC recommends to postpone surveying CPT code 76937 for two years until the October 2021 RUC Meeting.**

77001 ***Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)***
CPT Code 77001 was recently evaluated by the RUC in October 2015. At the January 2018 RUC meeting, the specialty societies requested that the RUC affirm the October 2015 value and inputs for code 77001. **The RUC recommends affirming the October 2015 RUC recommendation work RVU of 0.38 for CPT code 77001.**

Practice Expense
The PE Subcommittee removed time for sedation from CPT code 36572. The PE Subcommittee also made adjustments to the supplies including removing the shave prep tray (SA067), correcting the number of surgical gowns (SB028) and correcting the number of sanitizing and disinfecting wipes (SM022). **The RUC recommends the direct practice expense inputs 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.

<u>Biopsy or Excision of Inguinofemoral Node(s) (Tab 10)</u>
George A. Hill, MD (ACOG); Jon Hathaway, MD, PhD (ACOG); Mitch Schuster, MD (ACOG); Barbara Goff, MD (ACOG), Mark Shahin, MD (ACOG) and David Holtz, DO (SGO)
Facilitation Committee #2

In September 2017, the CPT Editorial Panel created a new code to describe biopsy or excision of inguinofemoral node(s). A parenthetical was added to codes 56630 and 56633 to instruct separate reporting of code 38531 with radical vulvectomy. This service was previously reported with unlisted code.

38531 ***Biopsy or excision of lymph node(s); open, inguinofemoral node(s) (For bilateral procedure, report 38531 with modifier 50)***
The RUC reviewed the survey results from 87 physicians and agreed with the following physician time component: pre-service time of 63 minutes, intra-service time of 65 minutes, post-service time of 30

minutes, one half-day discharge (99238), and two office visits (99213). The RUC compared CPT code 38531 to top key reference service code 38510 *Biopsy or excision of lymph node(s); open, deep cervical node(s)* (work RVU = 6.74) and the second top key reference code 38570 *Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple* (work RVU= 8.49). After review of the two key reference services, the RUC determined that the survey 25th percentile of 6.74 appropriately estimated the physician work of this service. **The RUC recommends a work RVU of 6.74 for CPT code 38531.**

Practice Expense
The RUC recommends the direct practice expense inputs without modification, as reviewed and approved by the PE Subcommittee.

Gastrostomy Tube Replacement (Tab 11)
Ethan Booker, MD (ACEP); Jordan Celeste, MD (ACEP); R. Bruce Cameron, MD (ACG); Dawn Francis, MD (AGA); Shivan Mehta, MD (AGA); Seth Gross, MD (ASGE); Vivek Kaul, MD (ASGE)

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M to the 19 services that truly met the criteria. The 19 services CMS identified that have not been reviewed as typically being reported with an E/M service will be placed on the next Level of Interest (LOI) form for survey and presentation at the April 2017 RUC meeting. In April 2017, the RUC reviewed recommendations for the codes identified by CMS and noted that the current survey data was bimodal with ED physicians reporting less time than gastroenterology and general surgery physicians. At the April meeting, the RUC determined that because ED physicians were the dominant Medicare provider (37%), the work RVU for 43760 would need to be reflective of the work and time for ED physicians. However, the RUC also noted that because the data was bimodal, it may be appropriate to consider changes in the CPT descriptors to better differentiate physician work**.** In September 2017, the CPT Editorial Panel deleted code 43760 and created two new codes that describe replacement of gastrostomy tube, with and without revision of gastrostomy tract, respectively.

43762 ***Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract***
The RUC reviewed the survey results from 185 emergency physicians and gastroenterologists and determined that a work RVU of 0.75 accurately reflects the physician work necessary for this service and falls well below the survey 25th percentile. As this code is typically reported with an Evaluation and Management (E/M) service on the same date of service, pre-service time package 1 was adjusted to 5 minutes for pre-service evaluation to account for overlap in time with an E/M reported on the same day. Scrub/dress/wait time was reduced to reflect the survey data median of 4 minutes because it is less than the package time. Similarly, the post-service time package 7A was reduced from 18 minutes to 8 minutes to reflect the survey median. The survey data strongly supports an intra-service time of 7 minutes. Thus, the RUC recommends the following time components: 10 minutes pre-service time (5 minutes evaluation time, 1 minute positioning time, and 4 minutes scrub/dress/wait time), 7 minutes intra-service time and 8 minutes immediate post-service time.

The RUC noted that CPT code 43762, for simple replacements, shares the same vignette and physician work as the predecessor CPT code 43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance*, which will be deleted from CPT in 2019. Code 43760 was most recently reviewed by the RUC at the April 2017 RUC meeting where the RUC recommended a work value of 0.75, below the survey 25th percentile. The rationale for valuation of CPT code 43760 was the result of considerable effort at understanding how to accurately assess the physician work for codes with very brief intra-service times, especially since the majority of codes that have some similarity have intra-service times of either 5 or 10 minutes and times of 7 minutes are rare for comparison. A collection of codes with intra-service times of 5-10 minutes was reviewed and a crosswalk was recommended to CPT code 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75 and 5 minutes of

intra-service time). For further support, the RUC recommends an additional crosswalk to CPT code 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscles* (work RVU = 0.75 and 10 minutes intra-service time). The RUC took into strong consideration the previous action of the Committee and recommends 0.75 work RVUs for CPT code 43762. **The RUC recommends a work RVU of 0.75 for CPT code 43762.**

43763 ***Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract***
The RUC reviewed the survey results from 81 general, pediatric and gastrointestinal surgeons and determined that the survey median work RVU of 1.41 accurately reflects the physician work necessary for this service. CPT code 43763 requires a different level of work complexity than 43762. It will be reported for the management of a patient who previously had a gastrostomy tube placed and the tube either fell out or became dislodged into the soft tissues of the abdominal wall and there has been a delay in presentation for replacement. The RUC agrees that CPT code 43763 represents more work for a different patient than described by the current (predecessor) CPT code 43760 and new code 43762.

CPT code 43763 will typically be provided by surgeons, not by emergency room physicians, family practice physicians, physician assistants or nurse practitioners who make up a majority of the current providers of CPT code 43760. These same providers also almost exclusively perform this procedure in the emergency department. Reported together data indicate that an E/M is typically reported only when 43760 is performed in the emergency department. The RUC does not anticipate that the procedure described by new CPT code 436X4 will be performed in the emergency department and therefore recommends pre-time package 2. The RUC removed two minutes from the extra positioning time requested for placing the patient in the supine position. The post-service time package 8A was reduced by 10 minutes to reflect the survey data which was less than the package time. The RUC recommends the following time components: 25 minutes pre-service time (18 minutes evaluation time, 1 minute positioning time and 6 minutes scrub/dress/wait time), 17 minutes intra-service time and 15 minutes immediate post-service time.

The RUC compared CPT code 43763 to key reference services CPT code 51710 *Change of cystostomy tube; complicated* (work RVU = 1.35 and 15 minutes intra-service time) and CPT code 51703 *Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)* (work RVU = 1.47 and 15 minutes intra-service time) and noted that both reference codes are typically performed in the office setting and reported with an office E/M, 44% and 41% of the time, respectively. In contrast, new CPT code 43763 will typically be provided in a facility setting with more than injection of local anesthetic and an E/M will not typically be reported.

For additional support, the RUC compared CPT code 43763 to MPC code 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44 and 17 minutes intra-service time) and noted that, although the intra-service times are identical, the MPC code has much less total time (29 minutes vs. 57 minutes) and a much higher IWPUT to reflect the increased intensity and complexity associated with repairing a wound of that length. Also, it is typically performed in the emergency department with injection of local anethetic and reported with an E/M code, unlike the survey code. The RUC concluded that CPT code 43763 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 1.41 for CPT code 43763.**

Flag for Review
The RUC recommends that these codes be reviewed by the Relativity Assessment Workgroup in two years to examine utilization data to determine if 90% of 43760 are directed toward 43762 and 10% to 43763, as predicted. The data should also examine if these codes are typically reported with E/M services and if the global period assignment should remain 000.

Practice Expense
The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee. Importantly, there is a 60% reduction in the estimated supply direct cost inputs due to the elimination of an expensive kit in lieu of the gastrostomy tube.

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.

Dilation of Urinary Tract (Tab 12)
Michael Hall, MD (SIR); Curtis Anderson, MD, PhD (SIR); Kurt Schoppe, MD (ACR); Daniel Wessell, MD, (ACR); Thomas M. Turk, MD (AUA); James Dupree, MD (AUA) and Kyle Richards, MD (AUA)

In October 2014, the CPT Editorial Panel deleted six codes and created 12 codes to describe genitourinary catheter procedures and bundle inherent imaging services. These codes were most recently reviewed by the RUC in January 2015. In January 2015, the specialty societies indicated that CPT code 50395 *Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous,* which was identified as part of the family, will be referred to the CPT Editorial Panel to clear up any confusion with overlap in physician work with 50432 *Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation*. The RUC recommended CPT code 50395 be referred to the CPT Editorial Panel. In September 2017, the CPT Editorial Panel deleted CPT code 50395 nephrostomy tract code and created two new codes to report dilation of existing tract, and establishment of new access to the collecting system, including percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy), all associated radiological supervision and interpretation, as well as post procedure tube placement when performed. Imaging is also now included in those codes.

Compelling Evidence
The specialty societies presented compelling evidence for CPT code 74485. The prior methodology for valuing this code is unknown and considered flawed, as the source is CMS/Other. In addition, the patient population for the use of this code has changed. In the past this code was mainly used by interventional radiologists for the dilation of a nephrostomy tract prior to nephrolithotomy. Dilation of nephrostomy tract is now part of CPT code 50436. Dilation of the lower urinary tract (urethra or lower ureter) is now the primary use of CPT code 74485 representing a substantial change in patient population. The RUC approved compelling evidence based on change in patient population and a flawed previous methodology.

50436 ***Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, as well as post procedure tube placement, when performed;***
The RUC reviewed the survey results from 73 interventional radiologists, radiologists and urologists and agreed on the following physician time components: 18 minutes for pre-service evaluation time, 1 minutes for pre-service positioning time, 6 minutes for pre-service scrub/dress/wait, 30 minutes for intra-service time and 15 minutes for immediate post-time. Image guidance previously separately reported with CPT code 74485 has been bundled into this new service.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 4.00. The RUC noted that the current value of 3.37 for deleted code 50395 *Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous,* which is being bundled with 74485 to create this new CPT code, would be appropriate. To justify a work RVU of 3.37, the RUC compared the survey code to MPC code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU= 3.20, intra-service time of 21 minutes, total time of 58

minutes), and noted that the survey code involves more intra-service and total time, though with somewhat less work intensity per minute, it is appropriate for the survey code to only be valued somewhat higher. The RUC also compared the survey code to reference code 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU= 3.50, intra-service time of 30 minutes, total time of 79 minutes) and noted that both services have identical intra-service time, whereas the reference code involves somewhat more total time. **The RUC recommends a work RVU of 3.37 for CPT code 50436.**

50437 ***Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, as well as post procedure tube placement, when performed; including new access into the renal collecting system***

The RUC reviewed the survey results from 68 interventional radiologists, radiologists and urologists and agreed on the following physician time components: 18 minutes for pre-service evaluation time, 1 minutes for pre-service positioning time, 6 minutes for pre-service scrub/dress/wait, 60 minutes for intra-service time and 15 minutes for immediate post-time. The specialties recommended and the RUC agreed that the survey 75th percentile intra-service time better represents the additional time needed to introduce the guidewire into the renal pelvis and/or ureter, above and beyond the work involved in perform 50436. Image guidance previously separately reported with CPT code 74485 has been bundled into this new service.

The RUC reviewed the survey 25th percentile work RVU of 5.44 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 5.44, the RUC compared the survey code to MPC code 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)* (work RVU= 5.44, intra-service time of 45 minutes, total time of 94 minutes) and noted that the survey code involves more intra-service and total time, though is a somewhat less intense service. To further support a value of 5.44, the RUC compared the survey code to 2nd key reference code 50694 *Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter* (work RVU= 5.25, intra-service time of 62 minutes, total time of 111 minutes) and noted that although the reference code involves somewhat more total time, both services have very similar intra-service times and 87 percent of the survey respondents that selected this reference code indicated that the survey code was more a more intense service. **The RUC recommends a work RVU of 5.44 for CPT code 50437.**

52334 ***Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde***

The RUC reviewed the survey results from 46 interventional radiologists and urologists and agreed on the following physician time components: 18 minutes for pre-service evaluation time, 6 minutes for pre-service positioning time, 6 minutes for pre-service scrub/dress/wait, 30 minutes for intra-service time and 15 minutes for immediate post-time. The specialties noted and the RUC agreed that the 6 minutes of positioning time was appropriate as this service is performed with the patient in the dorsal lithotomy position, which is the standard RUC pre-service time package addition for urologic procedures.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 4.21. To find an appropriate work RVU crosswalk, the RUC compared the survey code to deleted family code 50395 *Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous* (work RVU = 3.37, intra-service time of 30 minutes), and noted that both services involve an identical amount of intra-service time and the same amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk of CPT code 52234 to CPT code 50395. To further justify a work RVU of 3.37, the RUC compared the survey code to reference code 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck,*

prostatic fossa, urethra, or periurethral glands (work RVU= 3.50, intra-service time of 30 minutes, total time of 79 minutes) and noted that both services have identical intra-service time, whereas the reference code involves slightly more total time. **The RUC recommends a work RVU of 3.37 for CPT code 52334.**

74485 *Dilation of ureter(s) or urethra, radiological supervision and interpretation*
The RUC reviewed the survey results from 44 interventional radiologists, radiologists and urologists and agreed on the following physician time components: 3 minutes for pre-service time, 20 minutes for intra-service time and 5 minutes for immediate post-time. The RUC agreed that the previous times were erroneous as the prior methodology for valuing this code is unknown and considered flawed, as the source is CMS/Other.

The RUC reviewed the survey median work RVU of 0.83 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.83, the RUC compared the survey code to MPC 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, intra-service time of 15 minutes) and noted that the survey code involves more intra-service time and a similar amount of physician work. **The RUC recommends a work RVU of 0.83 for CPT code 74485.**

Affirmation of Current Values
The RUC affirmed the current values for CPT codes 50432 and 50433. These codes had been recently reviewed by the RUC in January 2015. The relativity within the family remains correct.

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

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

<u>Transurethral Destruction of Prostate Tissue (Tab 13)</u>
Thomas Turk, MD (AUA); James Dupree, MD (AUA); Kyle Richards, MD and Jonathan Rubenstein, MD (AUA)
Facilitation Committee #1

In September 2017, the CPT Editorial Panel created a new code to report transurethral destruction of prostate tissue by radiofrequency-generated water vapor thermotherapy. The RUC reviewed the family of codes for water vapor or steam thermotherapy and determined that the survey respondents overestimated the physician work for these services. Therefore, the RUC recommends appropriate crosswalks for each of these three codes. The RUC noted that the intra-service survey time decreases as the codes progress from CPT codes 53850 to 53852 and 53854. The RUC agreed that despite the decreases in intra-service time, the intensity of the procedures increases as the codes progress. CPT code 53850, the first code, involves more lower-intensity monitoring time, a less active task, while the second two codes, 53852 and 53854, are more engaged from a procedural perspective and include more intense activities (ie, active monitoring vs. actively operating). The third code in the family, CPT code 53854, is the most intense because of potential injury to adjacent structures. The crosswalks codify the progressive intensity in this family of codes with IWPUT of 0.041, 0.071 and 0.085, respectively. The RUC concluded that the work RVU crosswalk values more adequately match the survey reductions in time.

53850 ***Transurethral destruction of prostate tissue; by microwave thermotherapy***
The RUC reviewed the survey results from 47 urologists and recommends a work RVU of 5.42, which is supported by a direct work RVU crosswalk to CPT code 33272 *Removal of subcutaneous implantable defibrillator electrode* (work RVU = 5.42 and 39 minutes pre-service time, 45 minutes intra-service time and 25 minutes immediate post-service time) and falls well below both the survey 25th percentile. The codes have the exact same intra-service time and nearly the same total time. The RUC recommends 17 minutes evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 45 minutes intra-service time, and 10 minutes of immediate post-service time and 3- 99213 visits for CPT code 53850. This yields an IWPUT of 0.041 and the RUC determined that the longest procedure in the family should logically have the lowest IWPUT.

For additional support, the RUC reviewed CPT code 21013 *Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm* (work RVU = 5.42 and 45 minutes intra-service time) and CPT code 28039 *Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater* (work RVU = 5.42 and 45 minutes intra-service time) and noted that both codes have identical work RVU and intra-service time as the survey code. The RUC determined that the direct crosswalk recommendation of 5.42 work RVUs places this service in the proper rank order within this family. **The RUC recommends a work RVU of 5.42 for CPT code 53850.**

53852 ***Transurethral destruction of prostate tissue; by radiofrequency thermotherapy***
The RUC reviewed the survey results from 41 urologists and determined that of the 41 survey respondents for CPT code 53852, 20 reported experience and 21 did not. The intra-service median time was 30 for both sets of respondents. The RUC recommends a direct work RVU crosswalk to CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* (work RVU = 5.93 and 25 minutes pre-service time, 33 minutes intra-service time and 10 minutes immediate post-service time). The codes have the exact same total time and intra-service times are nearly the same. The RUC recommends 17 minutes evaluation time, 6 minutes positioning time, 5 minutes scrub/dress/wait time, 30 minutes intra-service time, and 15 minutes of immediate post-service time and 3-99213 visits for CPT code 53852. The specialty noted and the RUC agreed that the 6 minutes of positioning time was appropriate as this service is performed with the patient in the dorsal lithotomy position, which is the standard RUC pre-service time package addition for urologic procedures. Further, the RUC determined that, while CPT code 53850 has 10 minutes post-service time because a catheter is used, 53852 and 53854 require 15 minutes of post-service time because there are actual punctures of the prostate and the patient must be monitored due to greater occurrence of post-procedure hematuria.

For additional support, the RUC reviewed two laparoscopy codes, CPT code 58670 *Laparoscopy, surgical; with fulguration of oviducts (with or without transection)* (work RVU = 5.91 and 35 minutes intra-service time) and CPT code 58671 *Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)* (work RVU = 5.91 and 35 minutes intra-service time). The RUC determined that the direct crosswalk recommendation of 5.93 work RVUs places this service in the proper rank order within this family. **The RUC recommends a work RVU of 5.93 for CPT code 53852.**

53854 ***Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy***
The RUC reviewed the survey results from 42 urologists and recommends a work RVU of 5.93 which is supported by a direct work RVU crosswalk to CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* (work RVU = 5.93 and 25 minutes pre-service time, 33 minutes intra-service time and 10 minutes immediate post-service time) and falls well below both the survey 25th percentile. The RUC recommends 17 minutes evaluation time, 6 minutes positioning time, 5 minutes scrub/dress/wait time, 25 minutes intra-service time, and 15 minutes of immediate post-service time and 3- 99213 visits for CPT code 53854. The specialty noted and the RUC agreed that the 6 minutes of positioning time was appropriate as this service is performed with the patient in the dorsal lithotomy position, which is the standard RUC pre-service time package addition for urologic procedures. The RUC determined that 15 minutes of post-service time is appropriate due to greater occurrence of post-procedure hematuria

necessitating a longer monitoring time. The RUC recommends a direct crosswalk recommendation of 5.93 work RVUs and emphasized that CPT code 53854 is the most intense service in this family due to the use of hot water causing potential injury to adjacent anatomic structures. The crosswalk codifies the progressive intensity in this family of codes yielding an IWPUT of 0.085. **The RUC recommends a work RVU of 5.93 for CPT code 53854.**

Practice Expense
The Practice Expense Subcommittee made multiple revisions to the supplies, noting that each code uses a very expensive catheter, a different type for each method. The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee.

New Technology/New Services
CPT code 53854 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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.

Ultrasound Elastography (Tab 14)
Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Corinne Deurdulian, MD (ACR) and Eric Rubin, MD (ACR)

In September 2017, the CPT Editorial Panel created three new codes describing the use of ultrasound elastography to assess organ parenchyma and focal lesions: CPT codes 76981, 76982 and 76983. The most common use of this code set will be for preparing patients with disease of solid organs, like the liver, or lesions within solid organs. The additional work involved is the physiologic assessment of a diseased organ, the technical ability to evaluate the elastography data, and the training to understand the physics and appropriate quality control for elastography in addition to diagnostic ultrasound.

76981 ***Ultrasound, elastography; parenchyma (eg, organ)***
The RUC reviewed the survey results from 53 radiologists and determined that the survey 25th percentile work RVU of 0.59 accurately reflects the physician work necessary for this service. CPT code 76981 is a new, stand-alone code describing the evaluation of a solid organ using ultrasound elastography. The specialty explained that the physician is examining and evaluating the imaging of the organ and 7-10 sets of elastography images. The RUC recommends 5 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time. These pre and post-service times align with other comparable ultrasound and diagnostic radiology codes.

The RUC compared CPT code 76981 to the second highest key reference service CPT code 76705 *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)* (work RVU = 0.59 and 8 minutes intra-service time) and agreed that the physician work is similar to an abdominal ultrasound study. The specialty noted that the physician intra-service work in evaluating the patient directly and interpreting the images and making the clinical judgment is different work than is being performed in the limited or complete ultrasound. The radiologist interprets all images and evaluates stiffness measurements of the parenchyma of interest. The current exam is compared to any prior examinations to evaluate for stability or interval changes. The RUC also reviewed the top key reference service CPT code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81 and 11 minutes intra-service time) and noted that the complete abdominal ultrasound requires more measurements and the recommended value of 0.59 for CPT code 76981 is appropriately lower given the lower intra-service time for the survey code. The RUC concluded that CPT code 76981 should be valued at the 25th percentile as supported by the survey. **The RUC recommends a work RVU of 0.59 for CPT code 76981.**

76982 ***Ultrasound, elastography; first target lesion***
The RUC reviewed the survey results from 34 radiologists and determined that the survey 25th percentile work RVU of 0.59 accurately reflects the physician work necessary for this service. CPT code 76982 is a new stand-alone code describing the evaluation of a specific lesion within an organ, like a nodule in the breast, using ultrasound elastography. Approximately 3-5 sets of images are obtained and the components of the lesion are evaluated. The RUC recommends 5 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time as supported by the survey.

The RUC compared CPT code 76982 to the top key reference service CPT code 76776 *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* (work RVU = 0.76 and 10 minutes intra-service time). The reference code is a dedicated evaluation of a single organ, just like 76982 is a dedicated evaluation of a specific lesion. Both of these procedures have the same pre-, intra-, and post-service times; however, given the slightly higher complexity of evaluating a transplant kidney relative to the elastography of a single lesion, it is clinically appropriate that 76776 have a higher work RVU and IWPUT than the survey code. The RUC also compared 76982 to the second highest key reference service CPT code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56 and 10 minutes intra-service time) and noted that the codes have nearly identical values and times. The reference code has 2 minutes less of pre-service and post-service time and is a relatively less complex imaging exam than 76982, justifying a slightly higher work RVU for the survey code.

For additional support, the RUC compared the survey code to the third highest reference code 76882 *Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation* (work RVU = 0.49 and 11 minutes intra-service time) and noted that the recommended value of 0.59 for CPT code 76982 is appropriately higher than the comparator code given the survey code is more complex. The RUC concluded that CPT code 76982 requires the same physician time and work as 76981 and therefore should be valued the same. **The RUC recommends a work RVU of 0.59 for CPT code 76982.**

76983 ***Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 32 radiologists and recommends a work RVU of 0.50 which is based on a direct work RVU crosswalk to CPT code 15276 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.50 and 10 minutes intra-service time) and falls well below both the survey median and 25th percentile. CPT code 76983 is a new add-on code that describes the evaluation of an additional lesion using ultrasound elastography. The RUC recommends 9 minutes intra-service time.

The RUC compared CPT code 76983 to the top key reference service CPT code 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure*) (work RVU = 0.83 and 10 minutes intra-service time) and noted that both services are diagnostic imaging exams using the same modality (ultrasound) with relatively similar intra-service time. The reference code is correctly valued higher than 76983 because the complexity of assessing a twin gestation and the associated risks, are higher than the evaluation of a single lesion. The RUC agrees with the direct crosswalk recommendation of 0.50 work RVUs and noted that CPT code 76983 needed to be valued lower than the recommendations for the other two codes in order to avoid a rank order anomaly within the family. **The RUC recommends a work RVU of 0.50 for CPT code 76983.**

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

New Technology/New Services
These services will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Contrast-Enhanced Ultrasound (Tab 15)
Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Corinne Deurdulian, MD (ACR) and Eric Rubin, MD (ACR)
Facilitation Committee #2

In September 2017, the CPT Editorial Panel created two new codes describing the use of intravenous microbubble agents to evaluate suspicious lesions by ultrasound. CPT code 76978 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion* is a stand-alone procedure for the evaluation of a single target lesion. CPT code 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)* is an add-on code for the evaluation of each additional lesion. These codes will most often be used in patients with lesions in solid organs, such as a liver or kidney, who cannot or should not undergo dynamic multiphase contrast enhanced CT or MRI. Patients referred for these procedures include those who have significant renal impairment such that they cannot receive iodinated or gadolinium contrast, are pregnant, or younger patients who are more sensitive to radiation or may not tolerate MRI. In addition, for some patients with lesions in solid organs, these procedures may replace the use of CT or MRI, especially for follow-up of indolent malignancies (e.g. certain renal cell carcinomas) or previously treated tumors (e.g. status post ablation) or diagnosis of hepatic hemangiomas.

76978 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion*
The RUC reviewed the survey results from 41 radiologists and determined that the survey median of 1.82 overvalues the work required to perform this service, however the RUC agreed that the survey 25th percentile of 1.27 undervalues the work required to perform this service. The RUC also agreed that the recommended pre- and immediate post-service time was too high relative to other ultrasound services. The specialty society revised their recommendation, decreasing the physician time from 10 minutes to 5 minutes pre-service time and 10 minutes to 5 minutes immediate post-service time. The RUC recommends 5 minutes pre-service time, 20 minutes intra-service time and 5 minute post-service time. The RUC recommends a crosswalk to CPT code 73719 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)* (work RVU = 1.62 and 5 minutes pre-service time, 20 minutes intra-service time and 5 minutes post-service time).

The RUC discussed that the survey codes are used for patients with lesions in solid organs who cannot have standard contrast enhanced CT or MRI studies. The specialty expects that the number of CT and MRI studies may decrease. The specialty does not anticipate these exams to replace CT or MRI studies but rather to be used as a problem solving tool for appropriate patients. Both codes require direct hands-on involvement from the radiologist to ensure the appropriate lesion is targeted and observe the contrast enhancement pattern in real time by either injecting the contrast agent or scanning the patient while the contrast agent is injected. In approximately 5 percent of cases there are complications in using this new bubble contrast agent, most typically headache, light-headedness and nausea. The RUC compared 76978 to similar service 73222 *Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)* (work RVU = 1.62 and 20 minutes intra-service time) and noted that these services require similar physician work and time and should be valued the same. For additional support, the RUC referenced CPT code 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and*

with color flow Doppler echocardiography (work RVU = 1.50 and 20 minutes intra-service time) and noted that the survey code is appropriately valued higher because of the use of the bubble contrast. CPT code 93306 sometimes requires contrast, but it is not typical. **The RUC recommends a work RVU of 1.62 for CPT code 76978.**

76979 ***Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 31 radiologists and determined that the survey median of 1.10 overvalued the work of this service. The specialty society revised their recommendation to reflect the survey 25th percentile of 0.85 work RVUs and the RUC agreed that this accurately reflects the work value of this service. The RUC recommends 15 minutes of intra-service time for CPT code 76979. For additional support the RUC compared the survey code to MPC codes 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80, 15 minutes intra-service time) and 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)* (work RVU = 0.80, 15 minutes intra-service time). The survey code is appropriately valued higher because although there are efficiencies gained because it is the second lesion, it still requires similar intra-service work to the base code as real time decision making is needed requiring the physician to remain in the room to review the detail of the images. **The RUC recommends a work RVU of 0.85 for CPT code 76979.**

New Technology/New Services
These services will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The RUC discussed the new practice expense supply item, bubble contrast agent because a Committee member asked if it was possible to use saline rather than this fairly high cost supply. The specialty society explained that agitated saline is only used in echocardiography to assess for a left to right shunt. When intravascular contrast is used in echocardiography, as in this procedure, it is the aforementioned lipid stabilized microbubble contrast agent. This is the only agent that is FDA approved for contrast enhanced ultrasound. **The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee.**

<u>Magnetic Resonance Elastography (Tab 16)</u>
Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Suzanne Palmer, MD (ACR) and Eric Rubin, MD (ACR)

The CPT Editorial Panel created a new stand-alone code describing the use of magnetic resonance elastography for the evaluation of organ parenchymal pathology. This code will most often be used to evaluate patients with disease of solid organs (e.g. cirrhosis of the liver) or pathology within solid organs that manifest with increasing fibrosis or scarring. The goal with magnetic resonance elastography is to evaluate the degree of fibrosis/scarring (i.e. stiffness) without having to perform more invasive procedures (e.g. biopsy). This technique can be used to characterize the severity of parenchymal disease, follow disease progression, or response to therapy.

76391 ***Magnetic resonance (eg, vibration) elastography***
The RUC reviewed the survey results from 30 radiologists and determined that the survey 25th percentile work RVU of 1.29 accurately reflects the physician work necessary for this service. The RUC recommends 5 minutes pre-service time, 15 minutes intra-service time and 5 minutes immediate post-service time. The RUC discussed that magnetic resonance elastography is unlike routine magnetic

resonance imaging because the service requires the direct transfer of external pressure waves into the patient requiring the use of unique, MRI compatible hardware. This hardware includes the passive driver, which is placed directly on the patient, over the organ of interest and under the standard surface coil. The patient feels a physical "pounding" from the passive driver during the exam. The service requires more time because correct positioning of the passive driver over the organ of interest is critical. Repositioning of the driver is typical, requiring the physician to review the images at least two times to ensure accurate placement.

The RUC compared the survey code to the top two key reference services, CPT codes 74183 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences* (work RVU = 2.20 and 30 minutes intra-service time) and 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46 and 20 minutes intra-service time).Both services have higher work values which are justified by the higher intra-service times. The survey code is slightly more intense to perform due to the evaluation of wave propagation images and quantitative stiffness measures.

For additional support the RUC compared CPT code 76391 to MPC codes 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27 and 15 minutes intra-service time) and 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 18 minutes intra-service time). **The RUC recommends a work RVU of 1.29 for CPT code 76391.**

New Technology/New Services
These services will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The RUC recommends the direct practice expense inputs without modification as reviewed and approved by the PE Subcommittee.

Electroretinography (Tab 17)
David B. Glasser, MD (AAO); John T. McAllister, MD (AAO); John T. Thompson, MD (ASRS), Charlie Fitzpatrick, OD (AOA)

In the NPRM for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CMS identified CPT code 92275 via this screen. In January 2016, the specialty society noted that they became aware of inappropriate use of CPT code 92275 for a less intensive version of this test for diagnosis and indications that are not clinically proven and for which less expensive and less intensive tests already exist. The utilization of CPT code 92275 was appropriately low until 2013 when it suddenly increased by 300%. CPT changes were necessary to ensure that the service for which 92275 was intended was clearly described as well as an accurate vignette and work descriptor were developed. The RUC recommended CPT code 92275 be referred to the CPT Editorial Panel. In June 2017, the CPT Editorial panel deleted code 92275 and added a new code for full-field electroretinography (ERG). In September 2017, the CPT Editorial Panel replaced electroretinography code 92275 with two new codes to describe electroretinography full field and multi focal. A category III code was retained for pattern electroretinography.

92273 ***Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)***
The RUC reviewed the survey results from 34 ophthalmologists, optometrists and retina specialists and determined that the survey 25th percentile work RVU of 0.80 appropriately accounts for the work required

to perform this service. The RUC recommends 1 minute pre-time, 20 minutes intra-service time and 1 minute post-service time. This service is typically reported with an Evaluation and Management (E/M) service. The RUC noted that the pre- and post-times were significantly reduced from the survey time to ensure there is no overlap in physician work associated with the E/M included in this service. The 2 minutes of total pre and post time are for the physician to explain the exam and findings to the patient. The specialty society indicated that the decrease in intra-service time of deleted code 92275 from when it was last surveyed in 1995 is because the physician no longer participates in the acquisition of the data or performing the test on the patient, which is the technician's work. However, now there are more potential diagnoses and genotypes, thus the cognitive work by the physician has increased. The intra-service physician work includes reviewing numerous tracings and data, formulating a diagnosis, prognosis and potential therapeutic options. The physician reviews over 100 images and although the devices are sophisticated at collecting and presenting a desired output, the device does not indicate diagnostic suggestions. There is significant physician work interpreting the waveforms to arrive at a diagnosis of a typically rare disease with serious implications for the patient. The RUC determined that the recommended decrease in work RVUs appropriately addresses the decease in physician time to perform this service.

The RUC compared 92273 to similar service 92240 *Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* (work RVU = 0.80 and 20 minutes intra-service time) and noted that these services require the exact same physician work and time and should be valued the same. For additional support, the RUC referenced CPT code 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.93 and 22 minutes total time) which requires slightly more physician work but the same total time as the surveyed code. **The RUC recommends a work RVU of 0.80 for CPT code 92273.**

92274 ***Electroretinography (ERG), with interpretation and report; multifocal (mfERG)***
The RUC reviewed the survey results from 34 ophthalmologists, optometrists and retina specialists and determined that the survey 25th percentile work RVU of 0.72 appropriately accounts for the work required to perform this service. The RUC recommends 1 minute pre-time, 19 minutes intra-service time and 1 minute post-service time. This service is typically reported with an Evaluation and Management (E/M) service. The RUC noted that the pre- and post-times were significantly reduced from the survey time to ensure there is no overlap in physician work associated with the E/M included in this service. The 2 minutes of total pre and post time are for the physician to explain the exam and findings to the patient. The specialty society indicated that the decrease in intra-service time of deleted code 92275 from when it was last surveyed in 1995 is because the physician no longer participates in the acquisition of the data or performing the test on the patient, which is the technician's work. However, now there are more potential diagnoses and genotypes, thus the cognitive work by the physician has increased. The intra-service physician work includes reviewing numerous tracings and data, formulating a diagnosis, prognosis and potential therapeutic options. The physician reviews approximately 80 images and although the devices are sophisticated at collecting and presenting a desired output, the device does not indicate diagnostic suggestions. There is significant physician work interpreting the waveforms to arrive at a diagnosis of a typically rare disease with serious implications for the patient. The RUC determined that the recommended decrease in work RVUs appropriately addresses the decease in physician time to perform this service. The RUC also noted that CPT code 92274 is appropriately slightly less physician work than the full-field ERG CPT code 92273.

The RUC compared 92274 to similar service 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* (work RVU = 0.75 and 15 minutes intra-service time) and noted that CPT code 92274 is slightly less intense and complex to perform than 92235, therefore is valued lower. The RUC also referenced similar service, CPT code 77333 *Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)* (work RVU = 0.75 and 20 minutes total time). **The RUC recommends a work RVU of 0.72 for CPT code 92274.**

Practice Expense
The Practice Expense (PE) Subcommittee made minor adjustments to the original time inputs in order to more accurately reflect typical practice. The use of handheld and table top devices was discussed. Such equipment is not clinically appropriate for the services of fully dark-adapted full field and light-adapted multi focal ERG. The category III code representing pattern ERG would be represented by those services. CMS questioned the use of the contact lens electrode for the multifocal (92274) code as typical. Electrode contact with the ocular surface is a requirement in order to gain sufficient signal to accurately perform these tests. The specialty society indicated they queried the majority of facilities where 92273 and 92274 are performed across the country, and found that it is typical to use the reusable contact lens type of ocular surface electrode. The alternative to a contact lens electrode is to place silver wires across the conjunctival surface directly. The contact lens electrode requires less time to manipulate than the single electrodes. The silver wire electrodes must be manually placed across the conjunctiva and are more sensitive to signal loss with eye movement or blinking. Therefore, the more stable contact lens electrode is typically used. In addition to the contact lens electrode, skin electrodes are used for these services as well; however these electrodes were not included in the direct practice expense inputs, as they are reusable equipment that cost less than $500 and therefore would be considered indirect practice expense. **The RUC recommends the direct practice expense inputs 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.

Electrocorticography (Tab 18)
Marianna V. Spanaki, MD, PhD (AAN) and Marc Nuwer, MD, PhD (ACNS)

95836 is a new service approved at the September 2017 CPT Editorial Panel Meeting. Electrocorticography (ECoG) is the recording of EEG from electrodes directly on or in the brain. CPT Code 95829 is used for Electrocorticogram performed at the time of surgery; however a new code was needed to account for this non-face-to-face service, for the review of a month's worth or more of stored data. The new service is done in the outpatient setting, for review and interpretation of, on average, a month of recordings. ECoG brain wave activity is recorded by electrode contacts implanted onto or in the brain and relayed to a device implanted in the body. The device contains a microprocessor that monitors EEG activity and saves relevant portions for review and may deliver an electrical pulse to treat abnormal EEG activity in attempt to reduce seizures. The review and interpretation of the data by the care provider can be done at any time but a month's worth of accumulated ECoGs is typically reviewed at a time to monitor the patient and make treatment decisions.

95836 ***Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days***
The RUC reviewed the survey results from 53 neurologists and determined that the survey 25th percentile work RVU of 2.30 accurately reflects the physician work necessary for this service. The RUC recommends 22 minutes pre-service time, 30 minutes intra-service time and 5 minutes immediate post-service time. The device is placed under the skull and records activity continuously from the surface of the brain. It detects seizure patterns and it delivers stimulation on demand as pre-programmed by the physician non-invasively. It reduces seizure frequency by 50% in half of patients. The new code describes the work necessary to review the data produced from the device and it does not include programming of the device. This service is performed when the patient is not present. The population includes patients with frequent seizures who have not responded to medications, are not surgery candidates or have failed surgery. The RUC ensured that the pre-service time is not duplicative with an Evaluation and Management (E/M) service as the specialty society clarified that it is not appropriate to report an E/M if the patient comes into the office as a result of the data collected with this code. The physician would only report the procedure code which would include adjusting the settings on the neurostimulator and evaluating the reaction. This technology is used for severe cases involving a patient that seizes every day.

Patients are typically referred for this specialized care. As the physician providing this service is not the patient's treating physician, the RUC agreed that the extensive pre time is typical.

The RUC compared the survey code to the top key reference service, CPT code 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)* (work RVU = 1.98 and 55 minutes total time), noting that the survey respondents indicated that CPT code 95836 is more intense and complex than CPT code 95957 on all measures (mental effort/judgment, technical still/physical effort and psychological stress), which justifies the higher work value. The RUC also compared the survey code to second key reference service CPT code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 2.50 and 67 minutes total time), noting the reference codes higher total time which justifies the higher work value. **The RUC recommends a work RVU of 2.30 for CPT code 95836.**

Practice Expense
The RUC agreed with the specialty society that there is no direct practice expense associated with this service.

New Technology/New Services
These services will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Psychological or Neuro-psychological Test Administration (Tab 19)
Kevin A. Kerber, MD (AAN); Mary Newman, MD, MACP (ACP); Donna Sweet, MD, MACP (ACP); W. Bryan Sims, DNP, APRN-BC, FNP (ANA)

In the NPRM for 2016, CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. In January 2016, the specialty societies requested that the entire family of codes be referred to the CPT Editorial Panel to be revised. In June 2017, the CPT Editorial Panel revised 96116, added 13 codes to provide better definition and description to psychological and neuropsychological testing, and deleted codes 96101-96103, 96111, 96118, 96119, 96120.

At the October 2017 meeting the RUC determined that 96X11 P*sychological or neuropsychological test administration using single instrument, with interpretation and report by physician or other qualified health care professional and interactive feedback to the patient, family member(s), or caregivers(s), when performed* was not surveyed by physicians who will be providing this service (primary care and nurse practitioners). The RUC made an interim work RVU recommendation of 0.51 and recommended that this service be resurveyed by the correct providers for January 2018. The RUC also recommended that the specialty societies submit a revised vignette to the Research Subcommittee prior to survey.

In January 2018, the RUC identified significant concerns that the code descriptor did not accurately reflect the service and thus the survey data was likely flawed. The RUC indicated that, as currently described, this code would be used without interactive feedback, would substantially overlap with same day E/M, and would not typically take 15 minutes of intra-service time. Based on these concerns, the specialty societies agreed that the code descriptor should be refined. Specifically, the code descriptor should require interactive feedback and should require a minimum of 15 minutes intra-service time. **The RUC recommends that the CPT Editorial Panel rescind CPT code 96X11 for CPT 2019. The RUC recommends that CPT code 96X11 be referred back to the CPT Editorial Panel (September 2018) for further refinement to revise the code descriptor and include a time requirement (15 minutes).**

The family of psychological/neuropsychological testing CPT codes, except 96X11, was approved by the RUC in October 2017 and recommendations were submitted to CMS. Existing codes, 96103 and 96120, are scheduled to be deleted as of January 1, 2019. The RUC recommends that in the interim, a

parenthetical should be added that directs providers who will report these services to do so using the practice expense only code 96146; *Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only*. CPT code 96146 was passed by the RUC and submitted to CMS as part of the family of psychological and neuropsychological testing services following the October 2017 RUC Meeting. **The RUC rescinds its October 2017 interim recommendation to CMS for CPT code 96X11 only. The RUC recommends that the remaining codes in the family of psychological and neuropsychological testing submitted to CMS following the October 2017 RUC meeting be considered for the 2019 Medicare Physician Payment Schedule.**

Chronic Care Remote Physiologic Monitoring (Tab 20)
Richard Wright, MD, (ACC); Thad Waites, MD (ACC)

In September 2017, the CPT Editorial Panel revised one code and created three new codes to describe remote physiologic monitoring and management.

99457 ***Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month***
The RUC reviewed the survey responses from 53 cardiologists for CPT code 99457 and determined that the survey 25th percentile work RVU of 0.61 accurately accounts for the work required to perform this service. CPT code 99457 is a care management code that requires at least 20 minutes of service over a 30 day period in which the physician, qualified health care professional, or the clinical staff (i.e., nurse) interacts via communication with a patient. The typical time actually spent, however is 20 minutes by the physician or qualified health care professional and 40 minutes by the clinical staff (nurse). All data and any changes to the patients' care are documented in the electronic health record. The RUC recommends 20 minutes of intra-service time.

The RUC compared 99457 to the top key reference service 99490 *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month…* (work RVU = 0.61 and 23 minutes total time) and noted that these services required the same physician work and similar time to perform, and are appropriately valued the same. The typical patient receiving 99457 has a chronic disease; specifically heart failure and has a chronic heart failure management device at home to prevent hospitalization. Thus, CPT code 99457 is similar to the chronic care management code 99490. Additionally, both CPT codes 99490 and 99457 include physician time and clinical staff time. For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70 and 20 minutes total time), which requires similar work and the same total time. **The RUC recommends a work RVU of 0.61 for CPT code 99457.**

Practice Expense
The Practice Expense (PE) Subcommittee had an extensive discussion and confirmed that the devices for these services must be recognized as a medical device by the FDA and ordered by the physician or other qualified health care provider.

99453 ***Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment***
The PE Subcommittee discussed the specialty society's recommended supply items, shipping costs and a device reprocessing fee, and determined that they are not specifically allocable to the patient for this service, and would be considered indirect practice expenses. CMS confirmed that these items would be considered indirect practice expense under their methodology to calculate the practice expense relative value unit.

99454 ***Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days***
The PE Subcommittee maintained the specialty society's recommended supply item, a monthly service fee for the period of time being monitored. The PE Subcommittee also maintained the heart failure patient physiologic monitoring equipment, which the patient will have with them for the 30 days of the service. The RUC noted that unlike CMS' default assumption for equipment usage of 10 hours per day, 5 days per week, 50 weeks per year (for 150,000 total minutes of the year), the equipment for performing this service will be used 24 hours per day, 7 days per week, 365 days of the year (for 525,600 total minutes of the year). With this change to the utilization assumption for CMS' equipment cost formula, the net result is a rate 28.5% of the default, or 71.5% lower than the standard equipment cost per minute.

99457 ***Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month***
The PE Subcommittee confirmed that typically both the physician and the clinical staff communicate with the patient during the month. The clinical staff is making an average of 10 phone calls over the month and the provider will make 1-2 phone calls. These phone calls are not duplicative but complimentary services. The Subcommittee removed the desktop computer (ED021) as it would be considered indirect for this service.

The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.

New Technology/New Services
These services will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Interprofessional Internet Consultation (Tab 21)
Steve Krug, MD (AAP); Dennis Murray, MD (AAP); Mary Newman, MD (ACP) and Donna Sweet, MD (ACP)

In September 2017, the CPT Editorial Panel revised four codes and created two codes to describe interprofessional telephone/ internet/ electronic medical record consultation services.

99451 ***Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time***
The RUC reviewed the survey results from 55 internal medicine physicians and pediatricians for CPT code 99451 and determined a work RVU of 0.70, less than the survey median, is appropriate. The RUC recommends 15 minutes of intra-service time and 8 minutes of post-service time. The RUC determined that the physician work and time to perform 99451 is the same as CPT Code 99447 *Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review* (work RVU = 0.70 and 23 minutes of total time). CPT code 99447 requires both a verbal and written report, whereas 99451 requires only a written report but the intra-service time and intensity of these services are the same. The RUC could not justify a higher work RVU for CPT code 99451 based on the median survey results, therefore recommends a direct crosswalk to CPT code 99447. For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70 and 20 minutes total time), 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU = 0.70 and 23 minutes total time) and 88342

Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure (work RVU = 0.70 and 25 minutes total time). **The RUC recommends a work RVU of 0.70 for CPT code 99451.**

99452 ***Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes***
The RUC reviewed the survey results from 55 internal medicine physicians and pediatricians for CPT code 99452 and determined the survey respondents overestimated the physician work for this service relative to this family. In order to avoid a rank order anomaly, the RUC recommends a crosswalk to MPC code 99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU= 0.50 and 15 minutes of intra-service time). The RUC recommends 18 minutes of intra-service time for CPT code 99452, as indicated by the survey respondents. For additional support the RUC referenced code 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.48 and 16 minutes total time). The RUC noted that the treating physician may report an Evaluation and Management (E/M) visit on the same day as this service, but the time spent performing the interprofessional consultation must be 16-30 minutes above the work of the E/M in order to report 99452. Additionally, if time spent on the interprofessional telephone/internet/electronic health record discussion with the consultant exceeds 30 minutes beyond the typical time of the appropriate E/M service performed and the patient is present (on-site) and accessible to the treating/requesting physician or other qualified health care professional, the treating physician may report a prolonged services code instead as outlined in the introductory language. Therefore, CPT code 99452 may not be reported frequently. **The RUC recommends a work RVU of 0.50 for CPT code 99452.**

Practice Expense
The RUC agreed with the specialty that there are no direct practice expense inputs associated with these two services.

New Technology/New Services
These services will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 99446-99449. The relativity within the family remains correct.

IX. CMS Request/Relativity Assessment Identified Codes

Exploration of Artery/Vein (Tab 22)
Matthew Sideman, MD (SVS) and Charles Mabry, MD (ACS)

The RUC identified CPT code 35761 via the negative IWPUT screen for services with Medicare utilization over 10,000 and all services or over 1,000 for Harvard valued and CMS/Other source codes, for survey at the January 2018 RUC meeting.

CPT Referral
At the January 2018 RUC meeting, the RUC reviewed CPT code 35761 *Exploration (not followed by surgical repair), with or without lysis of artery; other vessels* and recommends referral to CPT. The RUC recommends referring CPT code 35761 and the family of codes (35701, 35721, 35741) to the CPT Editorial Panel to revise the "with or without lysis" language and to condense the code set, where applicable, due to low frequency. The appropriate global period for exploration (not followed by surgical repair) will also be considered after the CPT review. **The RUC recommends referring code 35761 and the family to CPT.**

Radioactive Tracer (Tab 23)
Kurt Schoppe, MD (ACR); Daniel Wessell, MD, PhD (ACR); Lauren Golding, MD (ACR); Gary L. Dillehay, MD (SNMMI) and Scott C. Bartley, MD (ACNM)

The RUC identified services with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. CPT code 38792 was identified via this screen for review.

Compelling Evidence
The specialty society presented compelling evidence for CPT code 38792 that the specialty performing this procedure has changed. Previously, the code was surveyed by general surgery during the RUC review performed in September 1998. Since that time, diagnostic radiology has become the dominant provider and was not a participant in the prior survey. When this service was last valued, the patient typically underwent general anesthesia in the OR, whereas now it is typical for this service to be performed in the nuclear medicine department while the patient is conscious. Furthermore, the service currently has a negative IWPUT, indicating that the service was previously valued under a flawed methodology. The RUC approved compelling evidence based on change in specialty and a flawed previous methodology.

38792 ***Injection procedure; radioactive tracer for identification of sentinel node***
The RUC reviewed the survey results from 103 physicians and agreed with the following physician time component: pre-service evaluation time of 8 minutes, pre-service positioning time of 3 minutes, pre-service scrub/dress/wait time of 3 minutes, intra-service time of 8 minutes, and post-service time of 5 minutes. The RUC determined that the length of pre-service time is appropriate due to the additional work involved in handling a radiopharmaceutical. In addition, since the patient is conscious, local anesthesia is now typical and occurs during the pre-service period. The specialties noted that this is an intradermal injection, which is relatively more intense than a subcutaneous injection. The RUC reviewed the recommended work RVU of 0.65, which is the 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 0.65, the RUC compared the survey code to reference code 51700 *Bladder irrigation, simple, lavage and/or instillation* (work RVU =0.60; intra-service time of 5 minutes, total time of 25 minutes) and noted that the survey code involves more intra-service and total time and should be valued somewhat higher than the reference code. For further support, the RUC compared the survey code to MPC codes 46600 *Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU = 0.55, intra-service time of 5 minutes, total time of 22 minutes) and MPC code 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscles* (work RVU = 0.75, intra-service time of 10 minutes, total time of 27 minutes) and noted that the survey code is evenly and appropriately bracketed by these reference service codes. **The RUC recommends a work RVU of 0.65 for CPT code 38792.**

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

Hemorrhoid Injection (Tab 24)
Stephen Sentovich, MD, FACS(ACS); Guy Orangio, MD, FACS (ASCRS); Charles Mabry, MD, FACS (ACS) and Nadar Massarweh, MD, FACS (ACS)

The RUC identified services with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. The RUC recommended that these services be surveyed for January 2018. CPT code 46500 was identified as part of this screen.

Compelling Evidence
The specialty societies presented compelling evidence that CPT code 46500 *Injection of sclerosing solution, hemorrhoids* that the original valuation was based on flawed methodology when it was reviewed in 2014. The specialty societies stated that CPT code 46500 possesses a negative IWPUT as the result of

CMS rejecting the RUC recommendation in 2014 and using a flawed methodology to calculate a work RVU based on a ratio of RUC recommended total time to Harvard total time. CMS used CPT codes 41825 *Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair* (work RVU = 1.41) and 10160 *Puncture aspiration of abscess, hematoma, bulla, or cyst* (work RVU = 1.25) as support for their recommendation, however, these codes are not valid comparators. Code 41825 is a Harvard-based code with specialty assigned time and visits and marked not to use to value physician work. Code 10160 includes a 99212 follow-up visit that does not include the added work of an anoscopy. In addition, CMS did not consider the information discussed by the RUC regarding the flawed Harvard data for 46500 and did not consider differences in intensity of work for different components of time (pre, intra, post). The RUC accepted compelling evidence on the basis of negative IWPUT which represents a flawed valuation methodology and further that a flawed methodology was utilized in deriving the existing value for CPT code 46500.

46500 *Injection of sclerosing solution, hemorrhoids*
The RUC reviewed the survey results from 37 colorectal and general surgeons and determined that the survey 25th percentile work RVU of 2.00 accurately reflects the physician work necessary for this service. The RUC recommends 8 minutes of pre-service evaluation time, 5 minutes of pre-service positioning time, 5 minutes of pre-service scrub/dress/wait time, 10 minutes intra-service time and 10 minutes immediate post-service time, yielding an IWPUT of 0.047. An Evaluation and Management (E/M) visit is typically reported with CPT code 46500. Thus, the pre-service evaluation time reflects a decrease from pre-time package 6 to account for a reduction in the evaluation time from 17 minutes to 8 minutes due to the history and physical performed as part of an E/M service. The pre-service positioning time has been increased by 4 minutes for prone positioning and the scrub/dress/wait time is 5 minutes for the anesthetic injection.

The RUC compared CPT code 46500 to the top key reference service CPT code 46221 *Hemorrhoidectomy, internal, by rubber band ligation(s)* (work RVU = 2.36 and 15 minutes intra-service time) and noted that the reference code has 5 more minutes intra-service time, justifying a higher work value than the survey code. Conversely, the RUC compared CPT code 46500 to the other key reference service CPT code 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* (work RVU = 1.61, 5 minutes intra-service time and 0.047 IWPUT) and noted that the reference code has 5 less minutes intra-service time, justifying a higher work value for the survey code. The recommended work RVU of 2.00 places the value correctly between the key reference services and results in similar procedure intensity. CPT codes 46500 and 46930 are reported for almost equivalent types of hemorrhoids (grade 1) and types of procedures which supports the 25th percentile for the survey code to have an equivalent IWPUT.

The RUC also reviewed MPC code 68810 *Probing of nasolacrimal duct, with or without irrigation;* (work RVU= 1.54 and 10 intra-service time) and noted that the codes have the same intra-service time but the comparison code includes a lower level follow-up visit and therefore correctly has a lower work RVU. The RUC concluded that CPT code 46500 as currently valued is too low and should rise to the 25th percentile supported by the survey. It was noted that in the previous survey from 2014, the 25th percentile was also 2.00. **The RUC recommends a work RVU of 2.00 for CPT code 46500.**

Practice Expense
The Practice Expense Subcommittee accepted the argument for compelling evidence based on a clarification that there are two separate anoscopies, and subsequent adjustments were made to clinical staff time and equipment times. Two new clinical activities codes were proposed that separately identify scope setup and cleaning at a postop global office visit, so these activities are not confused with time that is allocated for these same activities on the day of the procedure. The time for setting up and cleaning scope equipment is necessary when a scope is used during a procedure and when it is used at a postop office visit and CMS confirmed that other services also have this clinical staff time. When endoscopy is performed *at a follow-up postop visit* in a global period, it is not separately reportable and therefore the clinical staff time to

set-up and clean the equipment needs to be identified as a distinct activity from the postop office visit. 6 minutes of clinical staff time for a half day discharge was removed as the survey does not indicate that any discharge day management takes place. The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee.

Dual-energy X-Ray Absorptiometry (Tab 25)
Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Andrew Moriarity, MD (ACR; Gary L. Dillehay, MD (SNMMI); Scott C. Bartley, MD (AAN) and Fredrica Smith, MD (ACRh)

The RUC identified services with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. CPT code 77081 was identified via this screen for review.

77081 ***Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)***
The RUC reviewed the survey results from 67 physicians and agreed with the following physician time component: pre-service evaluation time of 2 minutes, intra-service time of 5 minutes, and post-service time of 2 minutes. The RUC reviewed the recommended work RVU of 0.20, which is the 25th percentile and agreed that this value appropriately accounts for the physician work involved. The RUC noted that the negative IWPUT was a result of the service previously having inflated pre-service and post-service times. This was a result of CMS not accepting the RUC recommendation for this service for CY 1998, but still implementing the RUC times. To justify the work RVU of 0.20, the RUC compared the survey code to MPC code 96521 *Refilling and maintenance of portable pump* (work RVU= 0.21, intra-service time of 4 minutes, total time of 10 minutes) and noted that the survey code involves slightly more intra-service time and slightly less total time, justifying a similar valuation. To further support a work RVU of 0.20, the RUC compared the survey code to CPT code 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU= 0.21, intra-service time of 5 minutes, total time of 9 minutes) and noted that both services typically take an identical amount of time to perform and involve a similar amount of physician work intensity. **The RUC recommends a work RVU of 0.20 for CPT code 77081.**

Practice Expense
The Practice Expense Subcommittee had reviewed and approved the compelling evidence request based on a change in dominant specialty in the non-facility setting and a change in the equipment typically used to perform this procedure. The Practice Expense Subcommittee made some minor reductions in the clinical staff times relative to what the specialties originally proposed. The non-facility PE inputs reflect the dominant provider in the office setting which is internal medicine. The Practice Expense Subcommittee recommended replacing the existing equipment input ER024 *densitometry unit, whole body, DXA* with the more expensive input ER019 *densitometry unit, fan beam, DXA (w-computer hardware)*, since the more expensive unit (ER019) is the unit that is typically in the internist's office. When patients are being screened for osteoporosis, a single appendicular measurement suggesting osteoporosis needs to be confirmed with axial skeleton imaging. ER019 can do both of those measurements. In addition, CPT code 77080, which has much higher utilization than 77081 and requires ER019, is often performed by internal medicine; internal medicine offices would not typically have both types of scanners.

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

Fibrinolysins Screen (Tab 26)
Jerry Hussong, MD, DDS, FCAP (CAP); Roger McLendon, MD, FCAP (CAP) and Ronald McLawhon, MD, FCAP (CAP)

The RUC identified services with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. The RUC recommended that these services be surveyed for January 2018. CPT code 85390 was identified as part of this screen.

Compelling Evidence
The specialty society presented compelling evidence for CPT code 85390 *Fibrinolysins or coagulopathy screen, interpretation and report* that the original valuation was based on flawed methodology and there has been a change in technique and physician work. CPT code 85390 was last reviewed by the RUC at its First Five-Year Review in 1995. At that time, the Agency did not agree with the RUC's recommendation, recording in the Final Rule that the "vignette used to survey the code represented services well beyond the interpretation of a single test and recommended maintaining the current value of 0.37." This reflected a misunderstanding of the RUC's recommendation that accounted for the professional work associated with the interpretation of *multiple* coagulation and hematology laboratory tests and comprehensive medical patient review. Thus, the service was valued based on the interpretation of only one test and patient review, maintaining the original Harvard-based value, resulting in a negative IWPUT. Pathologists who perform this service agree that a range of tests are ordered and interpreted. The specialty indicated that the typical patient scenario involves 4 or more test interpretations.

The specialty society described this code as a complex coagulation cascade analysis. It is a more complex analysis than in the past because progress has been made in the evaluation and understanding of the coagulation cascade and more assays are available. Further, a panel of coagulation experts agreed there are more tests to evaluate and the evaluation is more complicated. The RUC accepted compelling evidence on the basis of a negative IWPUT which represents a flawed valuation methodology and a change in the complexity of work.

85390 ***Fibrinolysins or coagulopathy screen, interpretation and report***
The RUC reviewed the survey results from 44 pathologists and determined that the survey 25th percentile work RVU of 0.75 accurately reflects the physician work necessary for this service. The RUC recommends 20 minutes of intra-service time, yielding an IWPUT of 0.038. There are multiple codes with 20 minutes intra-service time to support the 25th percentile recommendation including 88187 *Flow cytometry, interpretation; 2 to 8 markers* (work RVU = 0.74 and 20 minutes total time) and 88182 *Flow cytometry, cell cycle or DNA analysis* (work RVU = 0.77 and 20 minutes total time). The specialty stated that the type of smaller panels used in flow cytometry codes compared with the work in the survey code are considered fairly equivalent. Additional codes for comparison include 95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional* (work RVU = 0.77 and 20 minutes intra-service time), and 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75 and 20 minutes intra-service time).

The RUC noted that CPT code 85390 is the only interpretative code for the analysis of clotting disorders and is used only once per day in the interpretation of a number of assays. The RUC agrees that the physician work in providing this service has changed with a more complex patient population and with the existence of more tests allowing a better understanding of the coagulation disorder. It was noted that CPT code 85060 *Blood smear, peripheral, interpretation by physician with written report* (work RVU = 0.45) is just one of the standard assays that is evaluated in the coagulation work-up in CPT code 85390, which is currently valued at 0.37, providing evidence that the survey code is undervalued. Given the strong comparator codes and the increased complexity, the RUC agrees that CPT code 85390 as currently

valued is too low and should rise to the level of the survey 25th percentile. **The RUC recommends a work RVU of 0.75 for CPT code 85390.**

Practice Expense
The RUC agreed with the specialty society that since these services are currently provided almost exclusively in the hospital setting there are no direct practice expense inputs recommended with this service at this time.

Cardiac Output Measurement (Tab 27)
Cliff Kavinsky, MD (SCAI); Richard Wright, MD (ACC); Thad Waites, MD (ACC); David Kanter, MD (AAP); Steve Krug, MD (AAP); Sergio Bartakian, MD (SCAI)

The RUC identified services with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. The specialty societies noted that CPT code 93561 and 93562 are primarily performed in the pediatric population, thus the Medicare utilization for these Harvard –source services are not over 1,000. However, the specialty societies requested and the RUC agreed that these services should be reviewed under this negative IWPUT screen. The RUC recommended that these services be surveyed for January 2018.

Compelling Evidence
Change in Patient Population: CPT codes 93561 and 93562, first considered by the RUC in 1995, are Harvard valued. Historically, these codes were reportable with general cardiac catheterization codes that did not discriminate between non-congenital (typically performed in adults) and congenital (typically pediatric) patient populations. Congenital cardiac catheterization codes were added to CPT in 1998. Therefore, 93561 and 93562 were valued based on a non-congenital, adult patient population. Today, CPT codes 93561 and 93562 are only reportable in addition to the congenital cardiac catheter patient population, which are typically pediatric patients.

Incorrect Assumptions in Prior Valuation: Additionally, these codes were previously included in the Appendix G list of codes for which moderate sedation was inherent. Removal of the physician work value for moderate sedation from these adjunct procedures has compounded the negative IWPUT. CPT code 93561 previously had a value of 0.50, which was reduced to 0.25 and CPT code 93562 previously had a value of 0.16, which was reduced to 0.01 because CMS did not create a negative work RVU when it removed 0.25 for moderate sedation. Likewise, the negative IWPUT confirms that this previous methodology in which the current work RVU was derived from is flawed. **The RUC agreed that there is compelling evidence that the physician work for CPT codes 93561 and 93562 has changed based on a change in patient population and previous incorrect assumptions used in prior valuation.**

93561 ***Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 32 cardiologists and pediatricians and determined that the survey 25th percentile work RVU of 0.95 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes intra-service time. The RUC compared CPT code 93561 to top key reference service 93567 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)* (work RVU = 0.97 and 15 minutes intra-service), noting that these services require the same physician time and nearly the same physician work. For additional support the RUC referenced MPC codes 64484 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.00 and 10 minutes) and 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 15 minutes). **The RUC recommends a work RVU of 0.95 for CPT code 93561.**

93562 ***Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 30 cardiologists and pediatricians and determined that the survey 25th percentile work RVU of 0.77 appropriately accounts for the work required to perform this service. The RUC recommends 12 minutes intra-service time. The RUC noted that 93562 is sensibly less than 93561 as it requires slightly less physician time and work due to the physician's familiarity with the patients' anatomy that is garnered from the initial study. The RUC compared CPT code 93562 to top key reference service 93567 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)* (work RVU = 0.97 and 15 minutes intra-service), noting that CPT code 93562 requires slightly less physician time and physician work. For additional support the RUC referenced MPC codes 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 15 minutes) and 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 15 minutes intra-service time). **The RUC recommends a work RVU of 0.77 for CPT code 93562.**

Global Period
CPT Codes 93561 and 93562 are currently 000 global procedures with the antiquated "(separate procedure)" parenthetical. However, in reality they are always billed as an adjunct to congenital cardiac catheterization codes (93530-93533). In consultation with AMA RUC staff and AMA CPT staff submitted a parallel CPT code change application for consideration at February 2018 CPT meeting to align these codes with the current presentation of ZZZ global procedures codes which are tagged with an "add-on"/"+" sign and include "(List separately…)" language. The codes were surveyed as ZZZ procedures. The Research Subcommittee reviewed and approved the new vignettes in advance of the survey.

Practice Expense
The RUC agreed with the specialty that there are no direct practice cost inputs for this add-on service performed in a facility setting.

Peripheral Artery Disease (PAD) Rehabilitation (PE Only) (Tab 28)
Matthew Sideman, MD (SVS); Richard F. Wright, MD (ACC); Michael Hall, MD (SIR)

During 2017, CMS issued a national coverage determination (NCD) for Medicare coverage of supervised exercise therapy (SET) for the treatment of peripheral artery disease (PAD). Previously the service had been assigned PROCSTAT N (noncovered service by Medicare). CPT code 93668 was payable before the end of CY 2017, retroactive to the effective date of the NCD, and for CY 2018, CMS made payment for Medicare-covered SET for the treatment of PAD, consistent with the NCD, reported with CPT code 93668. CMS used the most recent RUC-recommended work and direct PE inputs and requested that the RUC review the service, which had not been reviewed since 2001, for direct practice (PE) inputs.

The RUC agreed that the staff type should be changed from an RN (L051A) to an RN/LPN/MTA (L037D). The bulk of the time is allocated to clinical activity *Perform procedure/service---NOT directly related to physician work time* (CA021) for 15 minutes. The clinical staff is monitoring the patients at a 4:1 ratio while they are using the treadmill for 1 hour, so the clinical staff devotes 15 minutes to the patient which correlates to 60 minutes of equipment time for EQ078, *cardiac monitor w-treadmill (12-lead PC-based ECG).* Additionally, the specialty recommended removing supply item SK068, *razor*.

The RUC recommends the direct practice expense inputs as reviewed and approved with modification by the PE Subcommittee.

X. Practice Expense Subcommittee (Tab 29)

Doctor Scott Manaker, Chair, provided a summary of the report of the Practice Expense (PE) Subcommittee:

- **Practice Expense Screens for Potentially Misvalued Services**
  The Practice Expense (PE) Subcommittee brainstormed screens that could identify potentially misvalued services. The PE Subcommittee came up with a screen for high cost supply items greater than $500. The recommendation will be forwarded to the Relativity Assessment Workgroup (RAW). The concern is depending on the dominant provider and utilization this could target a single or small number of specialties disproportionally, so there will be a number of associated data accompanying the recommendation for the RAW to review to determine a possible screen.

- **Minimum Multi-Specialty Visit Supply Pack Duplication Error**
  While working on a separate project, RUC staff discovered that there are 165 CPT codes billed together with an office evaluation and management or eye visit code more than 50% of the time in the nonfacility setting that have more minimum multi-specialty visit supply packs (SA048) then post-operative visits. The PE Subcommittee agreed that this is a simple duplication error that should be corrected by requesting that CMS remove the appropriate number of supply item SA048 from 165 codes as identified by the RUC.

- **Compelling Evidence Process**
  Although there appropriately remains a low bar to meet compelling evidence, as the PE Subcommittee works to better enforce compelling evidence guidelines, the Subcommittee has the potential to reject a presenting specialty societies' compelling evidence arguments if they do not find them persuasive. The PE Subcommittee discussed the appropriate action if they reject a compelling evidence rationale, and determined that the presenting specialty society will leave the table and revise their PE spreadsheet to remove enough direct cost to maintain budget neutrality for the direct practice expense cost of the service. This will keep the Subcommittee from facilitating at the table.

- **Issues for discussion from 2018 CMS Final Rule**

  Equipment utilization rate
  The PE Subcommittee discussed a number of implications around trying to get better data for equipment utilization rates. The PE Subcommittee discussed that it could not do better than CMS' current 50% utilization rate and determined that it was best to continue with that rate.

  Preservice clinical activities for 000 and 010 day global services
  The PE Subcommittee discussed the nomenclature of calling 0 minutes of pre-service time a "standard" for 000 and 010 day globals, recognizing that the CMS analysis showed that roughly 2/3 of 000 and 010 day globals have some pre-service staff time. There are currently a number of pre-service time packages that the specialties can recommend with appropriate rationale. The PE Subcommittee will continue with its current process; however the PE Subcommittee will change the language around this issue to state that the Subcommittee presumes zero minutes of pre-service clinical staff time until a convincing rationale is provided.

  Obtain vital signs clinical activity time standard
  In the CY 2018 NPRM, CMS proposed to change the standard for obtain vital signs to 5 minutes, irrespective of the number of vital signs taken. The Subcommittee identified several potential

adverse consequences to that proposal. The PE Subcommittee requested that staff provide data to inform discussion at the April 2018 RUC meeting.

Equipment recommendations for scope systems
The PE Subcommittee discussed the Scope Systems and Endoscopes Workgroup that had previously completed its work. There was a miscommunication between the Workgroup, the Subcommittee and CMS so the Workgroup will reconvene to complete its work, chaired by Doctor Barkley with members Doctors MacCormack, Cleveland and Sentovich as some additional members that are RUC advisors from societies that use endoscopic services codes.

- **Exam Table Included in Services Performed in an Ultrasound Room**
  The Subcommittee corrected a copy and paste error where an exam table was allocated to a service with an ultrasound room. The Subcommittee began to question if an exam table should ever be allocated to services performed in an ultrasound room. The table may very well be appropriate for the patient to recover after a procedure in the ultrasound room or it might be duplicative. The PE Subcommittee requested that staff provide data to inform discussion at the April 2018 RUC meeting.

- **Other Business**
  The PE Subcommittee discussed a number of issues that they chose not to pursue. The Subcommittee discussed improving the process for evaluating the serially revised spreadsheets throughout the meeting. The Subcommittee discussed trying to automate the PE spreadsheet to detect duplication, sending all of the revised spreadsheets to members of the PE Subcommittee in anticipation of the meeting and reiterated to the specialty societies to highlight changes in their spreadsheets (using yellow fill spreadsheet cells, red numbers). Finally, CMS requests and the PE Subcommittee agrees that the specialty societies should not include margin comments or detail on the spreadsheets and that all explanatory information should be included in the revised PE SORs.

The RUC approved the Practice Expense Subcommittee Report.

XI. Administrative Subcommittee (Tab 30)

Doctor Gregory DeMeo, Vice Chair, provided the Administrative Subcommittee report:

The Subcommittee discussed two items. 1) Reviewed and approved the candidates for the primary care and internal medicine rotating seats and 2) Discussed whether codes that have a very low response rates (under 30) should automatically be recommended for contractor pricing.

The Administrative Subcommittee reviewed the history of low survey responses and determined that the RUC should not automatically recommend contractor pricing codes that have a low response rate (under 30), but continue its current process and review each unique code set individually. The Subcommittee indicated that its main concern is that new Category I CPT codes are created when in reality the services are not widely performed and a valid survey with 30 responses is not obtainable. **The Administrative Subcommittee recommends that the RUC flag new Category I services with a survey response below 30 to be reviewed in three years by the Relativity Assessment Workgroup. Specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision to a Category III code.**

The RUC approved the Administrative Subcommittee Report.

XII. Relativity Assessment Workgroup (Tab 31)

Doctor Scott Collins, Chair, summarized the Relativity Assessment Workgroup (RAW) report:

- **Re-Review of Services – Action Plan Review (76942)**
  Throughout the RUC's review of potentially misvalued services, codes have been flagged for review at later date after additional utilization was available, CPT assistant articles were published or additional information was gathered. The Workgroup reviewed CPT code 76942 and noted that this service was recently bundled in 2015 and the clinical staff time is not duplicative, utilization of this service is going down. **The Workgroup recommends maintaining CPT code 76942 and complete for this screen.**

- **Surveyed by One Specialty, Now Performed by a Different Specialty – Action Plan Review (11981, 20225, 62270, 62368, 64590, 97598)**
  AMA Staff re-examined services that were surveyed by one specialty and are now performed by a different specialty based on 2016 Medicare utilization over 1,000. The Relativity Assessment Workgroup reviewed the action plans for these services and recommends:

CPT Code	Recommendation
11981 11980 (f) 11982 (f)	Refer to CPT to better define these services and differentiate between the use in musculoskeletal procedures and use in urological or gynecological procedures. May 2018 CPT or Oct 2018 CPT.
20225	Survey for 2020 cycle.
62270	Refer to CPT to bundle with 77003 and maintain the code without fluoroscopic guidance, for CPT 2020.
62368 62367 (f) 62369 (f) 62370 (f)	Review the direct PE inputs (specifically clinical staff time) for this family of services in April 2018. Maintain the work RVUs.
64590	Refer to CPT for revision to properly describe the service as performed by urology.
97598 97597 (f)	Survey April 2018. Specialty societies may determine to revise descriptor at CPT or revise 97598 to be an add-on service.

- **CMS/Other Source – Utilization over 30,000 – Action Plan Review (34 services)**
  In April 2017, the Relativity Assessment Workgroup noted that the RUC has identified and reviewed CMS/Other Source codes with utilization 100,000 or more and noted that the Harvard-Valued services with 30,000 have been reviewed. The Workgroup requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more and review at the October 2017 meeting. This list resulted in 34 services.

  The Workgroup reviewed the action plans in detail and noted that crosswalks to similar radiology services with low physician time and work RVUs are appropriate as a resurvey would not result in much variation. **The Workgroup indicated that the specialty societies must bring the crosswalk request to the Research Subcommittee for approval since it not a random survey.** The Workgroup noted that the Research Subcommittee previously approved this methodology.

The Workgroup questioned why the specialty societies were recommending crosswalks for some of the radiology services but surveys for other radiology services. The specialty societies indicated and the Workgroup agreed that cross-walking codes in which recent surveys were conducted for services of the same body region, similar times, and work RVUs are appropriate. Some upper extremity services were not recently surveyed therefore, the specialty society indicated that they should survey these as there is not a recent upper extremity crosswalk.

The Workgroup recommended:

CPT Code	Recommendation
70210 70220	Crosswalk like other recent similar radiology recommendations. April 2018.
70250 70260 (f)	Crosswalk like other recent similar radiology recommendations. April 2018.
70360	Crosswalk like other recent similar radiology recommendations. April 2018.
70480 70481 (f) 70482 (f)	Survey for October 2018.
72132 72131 (f) 72133 (f)	Survey for April 2018.
72190 72170 (f)	Crosswalk like other recent similar radiology recommendations. April 2018.
73000 73010 73020 73030 (f) 73050 (f)	Survey for April 2018.
73701 73700 (f) 73702 (f)	Survey for April 2018.
74240 74241 (f) 74245 (f) 74246 74247 (f) 74249 (f)	Refer to CPT May 2018 to revise to condense this family of services and combine fluoroscopy.
74250 74251 (f) 74260 (f) 74270 74280 (f)	Refer to CPT May 2018 to revise to condense this family of services and combine fluoroscopy.
75625 75630 (f)	Survey October 2018.
75726 75774	Survey October 2018.
76098	Survey April 2018.
76604	Survey April 2018.

CPT Code	Recommendation
77073 77074 (f) 77075 77076 (f) 77077	Survey April 2018.
88141	Survey April 2018.
92585	Refer to Feb 2019 CPT meeting to clarify the code descriptors to better define limited/comprehensive and develop a new related procedure, Vestibular Evoked Myogenic Potentials (VEMP), has recently been approved by the FDA. A VEMP specific code should be developed and will replace some use of CPT code 92585.
94200	Survey April 2018. The specialty societies can determine if they want to revise at CPT and should identify other codes that are part of this family.
95831 95832 (f) 95833 (f) 95834 (f)	Defer to April 2018. The Workgroup requests action plans on how to address 95831-95894. The specialty indicated that CPT code 95831should be considered services provided as part of an E/M. Each of the four codes in this family is primarily performed by different specialties. PT and Neurology agreed with the recommendation to delete code 95831 as it is probably being reported inappropriately. It appears a few providers in one state are primarily performing this service. The Workgroup will review this data in April 2018, with requested input from all societies that are primary utilizers within this code set.
G0124	Survey April 2018
G0279	Recommend CMS delete G0279 and use CPT codes 77061 and 77062 to report these services.
G0364	Deleted. New CPT code 38222 replaced G0364 for 2018.
G0365	Refer to CPT to convert to Category I code. CPT cycle 2020.
G0396	Maintain and Refer to CPT to change editorially remove "screening" from 99408 and 99409 to "assessment" to mirror G0396.
G0446	Survey April 2018.
G6002	Maintain. Specialty societies continue to work with CMS to cover Category I codes to report these services.

- **Reported Together 75% or More – Action Plan Review (4 issues)**
  Maintaining the consistency with previous iterations, AMA staff used the 2015 Medicare 5% sample claims data to determine when a code pair is reported on the same day, same patient and same NPI number at or more than 75% of the time. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in Medicare claims data and/or contained at least one ZZZ global service were removed. Based on these criteria four groups were identified (93503/36620, 32405/77012, 66711/66984, and 45381/45385). **The Workgroup reviewed the action plans for these services and recommended:**

CPT Codes	Recommendation
93503/36620	Maintain. These services were just reviewed in October 2016. These are two separate procedures that do not have overlap in work and do not directly contribute to each other. Thus, are not appropriate to be bundled together.
32405/77012	Refer to CPT to bundle. CPT 2020.
66711/66984	Refer to CPT to bundle or create add-on code. CPT 2020.
45381/45385	Maintain. The GI endoscopy codes reflect only the work involved in the procedure described. Therefore, if several procedures from the same endoscopy family are required and are performed during the same session, only the work of each individual procedure is captured. Because of application of the increment to physician work and the use of the multiple endoscopy reporting rule, there is no work or time overlap for individual procedures within the GI endoscopy families.

- **Work Neutrality (CPT 2016) – Action Plan Review (Intravascular Ultrasound 37252 & 37253)**
  Each year AMA staff reviews the utilization assumptions for work neutrality when the Medicare Utilization data for that year/cycle is available. Any code family that has an increase in work RVUs over 10% of what was estimated is reviewed by the RAW to determine what is occurring. Intravascular Ultrasound, CPT codes 37252 and 37253 that were reviewed at the January 2015 meeting and assumed to be a savings is actually a 44% increase in work RVUs from the old codes in 2015 to 2016 and the utilization was double from that of the coding structure, not even taking into account the radiological activities.

  The specialties that surveyed these codes in 2015 were ACC, SCAI, SIR and SVS. **These specialty societies indicated and the Workgroup agreed to review in April 2018 after reported together data is available. The Workgroup noted that its main concern with this family is regarding the practice expense inputs in the physician office.**

- **Low IWPUT (Informational Only)**
  In April 2017, the Relativity Assessment Workgroup discussed expanding a potentially misvalued services screen to those services with low IWPUT. The Workgroup noted that the 0.0224 is the IWPUT for pre-evaluation, pre-positioning and immediate post-service time. The Workgroup requested AMA staff to compile a list of all services with an IWPUT of 0.0224 or lower, which resulted in 161 services. In October 2017, the Workgroup determined that it would like to pare down the data to better assess whether this is an appropriate screen.
    - 010 and 090 day global codes only
    - IWPUT below 0.0224
    - Utilization over 30,000
    - Intra-service time greater than 15 minutes
    - RUC reviewed more than 5 years ago
    - Greater than zero pre and post service time (did not need to apply after the above criteria were applied)

  AMA staff ran the above criteria and no services were identified. Therefore, the Workgroup will not continue with this as an appropriate screen.

- **Informational Items**
  The following documents were filed as informational items: Referrals to the CPT Editorial Panel; Referrals to the CPT Assistant Editorial Review Board; Potentially Misvalued Services Progress Report and CMS/Relativity Assessment Status Report.

- **New Business**
  Review codes on the -51 modifier exempt list to make sure there is no duplication on pre- and post- work related to the services it is typically reported.

  The RUC approved the Relativity Assessment Workgroup Report.

XIII. Professional Liability Insurance (PLI) Workgroup (Tab 32)

Doctor Jennifer Wiler, Vice Chair, provided a summary of the Professional Liability Insurance (PLI) Workgroup report:

- Representatives from Acumen and CMS attended the meeting via teleconference to discuss recent premium data collection efforts by Acumen on behalf of CMS. The RUC in October had expressed strong concerns that CMS should be able to obtain premium information for all Medicare physician specialties, and other health care professionals.

  Significant discussion focused around the PLI RVU methodology and suggestions for refinements to more accurately reflect risk and premium costs of physicians. Further discussion involved the collection of PLI premium data on non-physician providers (NPP) who now comprise 20% of allowed charges within the Physician Fee Schedule. The PLI workgroup appreciates that CMS is willing to refine certain aspects of the data collection methodology, as demonstrated by the CY2018 final rule where the updated PLI premium data were not finalized after problems with it were pointed out by the RUC and other commenters. **The Workgroup will develop a letter to CMS with suggested improvements to data collection and classification. A conference call will be planned for March to review and finalize the letter for approval by the RUC in April 2018.**

- The PLI Workgroup reviewed an additional 28 codes that were identified for the list of expected/anticipated specialties for low volume services. The table of Codes Missing from the list of Expected Specialty Recommendations for Low Volume Codes was approved and submitted with the February recommendations to CMS.

  The RUC approved the Professional Liability Insurance Workgroup Report.

XIV. Research Subcommittee (Tab 33)

Doctor Margie Andreae, Chair, provided a summary of the Research Subcommittee report:

- **The Subcommittee reviewed and accepted the October 2017 Research Subcommittee report.**
  The Research Subcommittee report from the October 2017 in-person meeting and subsequent electronic review included in Tab 33 of the January 2018 agenda materials was approved without modification.

- **Review of Specialty Requests: Transcatheter Aortic Valve Replacement (TAVR)**
  At the October 2017 RUC meeting, the specialty societies involved requested that the TAVR family of codes be tabled and sent to the Research Subcommittee to develop a reliable methodology to value this unique set of services which are currently mandated by a national coverage determination (NCD) to include the participation of two physicians and use of modifier 62. The specialties outlined their concerns with valuing these codes using the current methodology during the discussion with the pre-facilitation committee and the RUC. These are currently the only codes in the fee schedule where the -62 co-surgeon modifier is required 100

percent of the time. As each co-surgeon receives 62.5% of the work value and each is performing the service and post-operative visit concurrently, this requirement may impact valuation and interpretation of code components (various types of work per unit time; time spent by each provider) making accurate value determination difficult. Furthermore, the specialties noted that the Research Subcommittee and the RUC had previously approved the TVT registry as an extant data source and it was unclear to the specialty societies how specifically these data points would be used in conjunction with the RUC survey data.

In October 2017, the RUC agreed to take no action on these codes and table their review until the April 2018 RUC meeting to provide the specialties and the Research Subcommittee sufficient time to resolve these methodologic issues. During the RUC's October 2017 other business discussion, the RUC agreed that specialties must provide both median and mean for extant data sources as these summary data would provide the RUC with a more complete picture of central tendency. Providing both median and mean would provide information as to whether the dataset is negatively or positively skewed and to what degree.

Prior to the January 2018 RUC meeting, the specialty societies submitted a letter with a series of questions to be discussed by the Research Subcommittee. At the January 2018 Research Subcommittee meeting, the Subcommittee had a discussion with presenters from the Society of Thoracic Surgeons (STS), American College of Cardiology (ACC), American Association for Thoracic Surgery (AATS) and the Society for Cardiovascular Angiography and Interventions (SCAI) addressing their questions.

During the discussion, the specialties noted that there has been a move to retire the NCD that mandates co-physicians for TAVR services, so there is a possibility that the NCD requirement could go away sometime in the future. (AMA Staff Note: The current CPT introductory language also states that "TAVR/TAVI requires two physician operators and all components of the procedure are reported using the 62 modifier.")

The societies proposed the idea of making an adjustment to the survey instrument or to the resultant survey data to directly account for the 62 modifier payment adjustment (ie. increasing the value of all of the reference service codes to align with the change in payment due to the modifier or transform the survey data work RVUs to account for payment policy). The Subcommittee expressed strong reservation with making any adjustment to either the survey instrument itself or to the survey RVU summary data. The Subcommittee noted that there is no existing precedent for making survey modifications based on Medicare payment policy. **The Research Subcommittee did not approve any modification to the survey instrument or the survey data to simulate the payment adjustment created by the 62 co-surgeon modifier.** The Subcommittee did note that that the specialties after following standard RUC survey process may provide additional rationale to support their recommendation. One idea suggested was to provide an adjusted IWPUT to account for the reduction (ie reducing the IWPUT by 37.5% to adjust for the payment policy) in addition to the standard IWPUT based on the survey. The specialties had also asked for comment on conducting a survey where the co-physicians were not required to complete the survey side-by-side and the Subcommittee noted that this was not a RUC requirement and therefore could not comment.

In discussing use of the extant database, the Subcommittee noted that, at the October 2016 RUC meeting, the Time and Intensity Workgroup recommended and the RUC approved that "*If a specialty has a RUC-approved source of extant physician time data, then that Specialty can use this methodology as supporting evidence for their RUC recommendation, though they would still be required to conduct a RUC survey*." The Subcommittee clarified that because the current RUC database is based predominantly on survey data, it is important to continue to use survey data to maintain relativity across services. While a data source that is based predominantly on measured data may be more accurate, it creates challenges with relativity. **The Research Subcommittee**

recommends for the RUC to continue to require a RUC survey and presentation of survey data when data from a RUC-approved extant database is also available. The Subcommittee noted that data from the RUC-approved extant database may be used to support the advisory committees' recommendation.

The Subcommittee also discussed use of mean versus median summary data. The Subcommittee noted that both the mean and the median values provide different useful information. **The Research Subcommittee recommends for the RUC to continue requiring both the mean and the median physician times drawn from a RUC-approved extant database.** The Subcommittee noted that the specialties may provide rationale on why one value is preferable to another on a case-by-case basis. The Subcommittee clarified that it is not within their purview to indicate how the RUC will use data.

- **RUC Crosswalk Recommendations**
  At the October 2017 meeting, the RUC referred a request to Research Subcommittee to review the RUC's recent usage of crosswalk codes and whether further rules/guidelines are necessary. The RUC requested for AMA staff to perform an analysis of previous RUC recommendations based on crosswalks. AMA staff analyzed 468 codes from the past 6 RUC/HCPAC meetings. 104 (22%) of these recommendations were based on a crosswalk. When the RUC recommendation was based on a crosswalk code, the RUC always recommended an identical work RVU. In addition, both services had identical global period assignments 95% of the time. A significant number of the codes (79% intra-time and 60% total-time), the RUC recommended time was within 10% of the time for the crosswalk code. Nearly every crosswalk code selected had been reviewed by the RUC (98%).

  After review of the analysis prepared by AMA staff, the Subcommittee concluded that the RUC has an excellent track record over the past two years of selecting appropriate crosswalks and no defined guidelines are indicated. **The Research Subcommittee requested for AMA staff to conduct this analysis again in two years for the Subcommittee's review.**

- **000-day Global Codes Typically Billed with E/M Services**
  At the April 2017 RUC meeting, during *Other Business,* a RUC member requested that methodological issues related to procedure with 000-day global typically billed with E/M be referred to the Research Subcommittee. The RUC has identified codes that are typically reported with E/M on the same date to ensure that there is no duplication of pre and post work. The member requested review to ensure that there was greater standardization approach to pre and post work identified for the 000 day global procedures that are deemed to be above and beyond the E/M reported on that same date.

  AMA staff performed an analysis of existing codes from the past four RUC meetings to illustrate pre and post modifications made to procedures with 000-day global period assignments.

  One Subcommittee member suggested that in their view, they did not think that there should be any additional pre-service evaluation time for a procedure if it was inherently performed (75% of time or more) on the same date as an E/M. Other Subcommittee members did not agree with this assertion and noted that there is evaluation time for the procedure that goes above and beyond the E/M performed on the same date. The Subcommittee agreed to continue this discussion in April 2018. Staff will provide a table with the procedure codes with a 000 day global period that are performed with E/M 75% of the time or more, along with the pre-evaluation time for these services.

  The Research Subcommittee requested for AMA staff to work with several volunteers from the Subcommittee to ensure that the RUC survey instructions are clear on the exclusion of time for

evaluation otherwise included in the same-day E/M. Proposed revisions will be considered at the April 2018 RUC meeting.

- **Standard Survey Language Solutions for Time-Based Codes**
  Following the June 2017 Research Subcommittee conference call, a member recommended that the Subcommittee discuss potential standard solutions for surveying time based codes. In the past, certain time based codes have had custom question pertaining to the typical number of units of the code and/or pertaining to the total time involved in performing the service added to the survey. Specialties have also employed custom disclaimer text throughout the survey templates and survey distribution emails. Bolding and underlying text has also been utilized.

  At the October 2017 meeting, the Research Subcommittee noted that recently it has been somewhat common for the HCPAC to review time-based CPT Codes and that valuing these services has proven somewhat difficult. Currently, on a case by case basis, specialties have proposed custom survey language to capture the amount of time units a service typically takes. Members suggested having survey language options available to societies may simplify their efforts when clarifying their surveys. The Research Subcommittee requested for AMA Staff to assemble examples of language used in the past and also noted that they would continue discussing this issue at the January 2018 meeting.

  At the January 2018 meeting, the Subcommittee reviewed custom language recently used for time-based codes as well as draft language provided by AMA Staff.

  The Subcommittee expressed some interest in using some version of the proposed draft language. A Subcommittee member inquired whether it may be more appropriate to instead directly ask the respondent to estimate the units of the code that they would typically report. AMA staff noted that their rationale for keeping the question related to total time, instead of units of service, was so that the survey respondents would not need to have a complete understanding of the sometimes complex rules for reporting time-based codes. **The Research Subcommittee requested for AMA staff to draft a standard sample survey instrument for time-based codes for the April 2018 meeting.**

- **Typical Vignettes Analysis by AMA Staff**
  At the October 2017 meeting, the Research Subcommittee agreed upon prominent instructions stating that survey respondents should value the services based on the provided typical patient. The Research Subcommittee also requested for AMA Staff to perform an analysis for the January 2018 RUC Meeting regarding how often survey codes that received RUC recommendations had less than 50 percent agreement with the provided vignette. AMA staff provided an analysis of all final recommendations submitted to CMS from the past 6 meetings. The analysis only included data from codes that had RUC recommended value (ie data from services referred to CPT were excluded). The analysis showed that 96 percent of the codes reviewed over the past 6 meetings had over 70 percent of respondents indicate that the provided vignette was their typical patient. After reviewing the data provided by AMA staff, the Subcommittee agreed that the vignettes included in recent surveys represent the typical patient for the vast majority of survey respondents and no concerns were validated. The Subcommittee also noted that recent new language was added to the surveys to instruct the respondent to base their selections on the patient in the vignette even if they did not agree that this was their typical patient.

- **Other Business**
  Minutes from December 4, 2017 Ad Hoc Pre/Post Time Package Workgroup Conference Call

  The Research Subcommittee has charged the Ad Hoc Workgroup with reviewing the existing pre-service and post-service time packages and recommended new and revised time packages if deemed necessary. The Chair of the Ad Hoc Workgroup provided a brief overview of the topics discussed on the call, including how to define a complex patient, whether the current packages need to be updated and also how to create non-facility post-service time packages. The Workgroup requested for AMA staff to provide several analyses, including an analysis with the 25th percentile, median and 75th percentile pre- and post-service times, a comparison between the survey times and the final RUC recommendations for the past few meetings. The Workgroup also requested for AMA staff to provide more detailed history on how the current times were assigned to the packages. The Workgroup will schedule another call prior to the April 2018 RUC meeting.

  The RUC approved the Research Subcommittee Report.

XV. Anesthesia Workgroup (Tab 34)

Doctor Verdi DiSesa, Chair, provided the Anesthesia Workgroup report:

- **Validate 2007 Anesthesia Methodology**
  The Chair indicated that at the October 2017 Anesthesia Workgroup meeting, the Workgroup determined that before it can reliably value anesthesia codes it must first validate a methodology to identify a set of anchor or reference codes. At this meeting the American Society of Anesthesiologists (ASA) was asked to update and explain the 2007 methodology last used for this purpose. AMA staff noted that 8 of the top 32 anesthesia codes have a single surgical code that is reported at least 50% of the time with the anesthesia code. The Workgroup requested that the specialty society review the 2007 methodology and confirm or revise the methodology using the 8 codes as an example.

  ASA presented the 2007 building block methodology updated with 2018 data and some new assumptions. The Workgroup determined that it would not be appropriate to use the building block method to develop recommendations for valuation of anesthesia services. However, this methodology, suitably modified, may be useful to demonstrate relativity between anesthesia services and to establish a set of reference codes that may be used to establish a magnitude estimation survey of base units. The Workgroup discussed and thereafter requested that ASA review and revise elements of the building block methodology discussed at the meeting and including, but not limited to:
  - Pre-service evaluation time – revise codes with a base unit of 16-30 which are referenced to code 99252 *Inpatient consultation for a new or established patient* (work RVU=1.50) since this service is considered "invalid" under the MFS.
  - Provide more granularity and greater consistency among the categorization of codes within each step in the methodology and review current definitions for the surgical code pre and post categories in order to determine if there is a similar structure that may be used. For example, in the present version of the building block methodology, the pre-service evaluation times currently are divided into 4 groups based on base unit values of 3, 4, 5-15 and 16-30. These categories may not provide sufficient granularity at the higher values and vary from other steps in the process and therefore may not represent the most appropriate way to categorize these data.
  - Equipment, drug and supply preparation – revise the base RVU assumption which currently includes a comparison to CPT code 99157 *Moderate sedation* (IWPUT 0.0833) as this has a high value compared to standard scrub, dress and wait intensity of 0.0081 which was used in the 2007 methodology .

- Members of the Workgroup and the representatives of the specialty society were encouraged to propose other refinements to the proposed building block methodology and to incorporate them in a refined proposal to be presented at the April 2018 meeting.

The Workgroup also discussed the pitfalls of attempting to develop a methodology for comparing anesthesia base units to physician work RVUs. After some discussion, the Workgroup determined that it would focus on defining a method to determine relativity between anesthesia services compared to other anesthesia services. Given the relatively few degrees of freedom inherent in the Congressionally-mandated system of anesthesia base units, the Workgroup thought it unnecessary at this time to develop a technique for the precise determination of relativity between anesthesia base codes and work units of all other physician services.

The Workgroup supports the concept of attempting to devise a refined building block methodology which would be used to construct an anesthesia reference service list to be used to develop appropriate base units for anesthesia services. The Workgroup requested that the ASA incorporate the suggestions of the Workgroup to refine the building block method and to apply this method for discussion at the next Workgroup meeting, to the same 8 anesthesia codes presented at this meeting.

- **Review analysis comparing the physician work component of anesthesia base units to work RVUs – Top 5 surgical services provided for each anesthesia code**
  The Workgroup had requested that AMA staff gather the top 5 surgical services for each of the top 32 anesthesia codes and display the surgical codes IWPUT compared to the Post-Induction Period Procedure Anesthesia (PIPPA) of the anesthesia codes for review at the January 2018 Workgroup meeting. The Workgroup had a brief discussion of these data without articulating the specific ways in which they might be used.

  In April 2018, the Anesthesia Workgroup will review ASA's revised building block methodology assumptions for the 8 codes as a first step in developing an anesthesia reference service list. The Workgroup requested that staff schedule a 2-3 hour meeting of the Workgroup at the April 2018 RUC meeting in order to allow adequate time to discuss these complex issues.

  The RUC approved the Anesthesia Workgroup Report.

XVI. RUC HCPAC Review Board (Tab 35)

Doctor Dee Adams Nikjeh, Co-Chair, provided a summary of the HCPAC Review Board Report:

The Health Care Professionals Advisory Committee (HCPAC) Review Board did not have any codes to review at this meeting so the Committee took the opportunity to have a discussion about RUC and HCPAC policies and processes. The HCPAC had very good discussions about compelling evidence, the lobbying policy, the work RVU evaluation and practice expense. The HCPAC further reviewed the appeals process. The HCPAC noted that the appeals process policy is very vague and simple refers one to the American Institute of Parliamentarians "Standard Code of Parliamentary Procedure", which is also vague. The HCPAC requests that the Administrative Subcommittee review the current language of this document and possibly provide more definitive language defining criteria for an appeal. Perhaps similar to the criteria for compelling evidence. This request for referral will be reiterated during other business.

The RUC filed the HCPAC Report.

XVII. Rotating Seat Elections (Tab 36)

- Jennifer R. Aloff, MD, American Academy of Family Physicians (AAFP), was elected to the RUC's Primary Care rotating seat.

- Daniel McQuillen, MD, Infectious Diseases Society of America (IDSA), was elected to the RUC's Internal Medicine rotating seat.

- The term for the rotating seats is two years, beginning in March 2018 and ending in February 2020 with the provision of final recommendations to CMS.

XVIII. New Business/Other Issues (Tab 37)

Referrals to the Administrative Subcommittee:

- A RUC member asked for clarification on whether a RUC member serving on a multi-specialty or AMA workgroup is precluded from speaking at the table.

- HCPAC requested a review of the language on the appeals process to provide more definitive language.

Referrals to the Research Subcommittee:

- A letter from the specialties involved with the survey process for transitional care management services was raised. It requests that a workgroup be appointed to develop new standardized survey instruments for non face-to-face services, for both physicians and relevant clinical staff, in order to more accurately value these services.

- A RUC member observed that there are XXX codes with similar descriptions of pre and post-service work but very different time allotments. The subcommittee will examine pre and post-service work in XXX codes and look at the range of work descriptors and the range of times assigned to determine if any action needs to be taken.

- A RUC member proposed updating the survey instrument to inquire for low volume services whether survey respondents have performed the survey code in the past few years instead of only the past 12 months. They noted that knowing this additional information may be beneficial when a survey code has a median performance rate of zero for the past 12 months.

The RUC adjourned at 2:30 p.m. on Saturday, January 13, 2018.

Members Present: Scott Manaker, MD, PhD, (Chair), David C. Han, MD (Vice Chair), Kathy Krol, MD (CPT Resource), Gregory L. Barkley, MD, Eileen Brewer, MD, Joseph Cleveland, MD, Neal H. Cohen, MD, William Gee, MD, Mollie MacCormack, MD, FAAD, Dheeraj Mahajan, MD, Alnoor Malick, MD, Mary Newman, MD, Tye Ouzounian, MD, Rick Rausch, PT, Stephen Sentovich, MD, Ezequiel Silva, III, MD, W. Bryan Sims, DNP, APRN-BC, FNP, Lloyd Smith, DPM; Thomas Weida, MD, Adam Weinstein, MD

I. Practice Expense Screens for Potentially Misvalued Services

The Practice Expense (PE) Subcommittee brainstormed screens that could identify potentially misvalued services. **The PE Subcommittee recommends the following screens to the Relativity Assessment Workgroup (RAW):**

- **High cost supply items –There are 33 supply items with a purchase price greater than $1000 and 55 supply items with a purchase price greater than $500. The PE Subcommittee recommends that the RAW identify services that include supply items greater than $500 and based upon utilization, dominant specialty and date of last review, determine whether or not there is reason for RUC review.**

II. Minimum Multi-Specialty Visit Supply Pack Duplication Error

While working on a separate project, RUC staff discovered that there are 165 CPT codes billed with an office evaluation and management or eye visit code more than 50% of the time in the nonfacility setting that have more minimum multi-specialty visit supply packs (SA048) then post-operative visits. This indicates that either they were not billed with an E/M when they were reviewed by the PE Subcommittee or more likely the PE Subcommittee approved a minimum multi-specialty visit supply pack (SA048) without considering the resulting overlap of supplies between SA048 and the E/M supply pack (SA047). Staff considers this to be a simple duplication error that should be corrected by requesting that CMS remove the appropriate number of supply item SA048 from 165 codes as identified by the RUC.

The contents of SA047 and SA048 are outlines below. All the items contained in SA048 are also contained in SA047 with additional items.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, e/m visit	**SA047**	**pack**		**2.984**
cover, thermometer probe		item	1	0.038
drape, non-sterile, sheet 40in x 60in		item	1	0.222
gloves, non-sterile		pair	2	0.084
gown, patient		item	1	0.533
paper, exam table		foot	7	0.014
patient education booklet		item	1	1.550
pillow case		item	1	0.307
specula tips, otoscope		item	1	0.030
swab-pad, alcohol		item	2	0.013
tongue depressor		item	1	0.012

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**1.143**
paper, exam table		foot	7	0.014
gloves, non-sterile		pair	2	0.084
gown, patient		item	1	0.533
pillow case		item	1	0.307
cover, thermometer probe		item	1	0.038

The PE Subcommittee agrees that a SA048 should not be allocated as a supply item for services that are typically billed with an E/M service on the same day, since SA047 already has all the supplies necessary to perform both services. **The PE Subcommittee recommends that CMS remove the appropriate number of supply item SA048 from 165 codes as identified by the RUC.**

III. Compelling Evidence Process

Since the direct cost calculations were added to the PE Spreadsheet, the PE Subcommittee has begun to use these cost estimates, rather than the number of clinical activity minutes, supplies item and equipment minutes; as a means to determine if a compelling evidence argument is required of the presenting specialty societies. Although there appropriately remains a low bar to meet compelling evidence, as the PE Subcommittee works to better enforce compelling evidence guidelines, the Subcommittee has the potential to reject a presenting specialty societies' compelling evidence arguments if they do not find them persuasive. **The PE Subcommittee discussed the appropriate action if they reject a compelling evidence rationale, and determined that the presenting specialty society will leave the table and revise their PE spreadsheet to remove enough direct cost to be equal to or less than the current (or predecessor code) direct cost of the service. The presenters will return at the end of that day and present their revised recommendation.**

The PE Subcommittee noted that the specialty societies should routinely submit paid invoices when recommending new supplies and equipment. The use of the new direct cost calculations has made this even more important because if paid invoices are submitted to CMS directly from the specialty societies after the meeting and the cost estimates are not provided in the PE spreadsheet, the specialty could potentially avoid presenting a compelling evidence argument for a code that will ultimately increase in direct costs.

IV. Issues for discussion from 2018 CMS Final Rule

- **Equipment utilization rate**

In the CMS CY 2018 Final Rule, a commenter suggested that "CMS should work with the RUC to determine a more valid utilization rate, including the possibility of specialty-specific equipment utilization rates." Although the PE Subcommittee agreed that the 50% utilization rate and 90% utilization rate for imaging equipment is not always appropriate, they agreed that the rates were reasonable. The PE Subcommittee then discussed that a specialty-specific equipment utilization rate rather than the current system wide rate could only be determined through a large scale specialty level survey or study. The Subcommittee discussed that although the results of such a survey would be valuable, it would also be a large undertaking. **The PE Subcommittee**

ultimately determined that it would not pursue a survey for the equipment utilization rate at this time.

- **Preservice clinical activities for 000 and 010 day global services**

In the CY 2018 Notice of Proposed Rulemaking (NPRM), CMS noted that although the standard pre-service time for 000 and 010 day globals is 0 minutes, 41 of the 53 reviewed codes for 2018 with 0-day or 10-day global periods include preservice clinical labor of some kind. CMS requested comments on whether or not they should apply the "standard" of zero preservice time for all 0-day and 10-day global period codes in future rulemaking. In the RUC comment letter, the RUC urged CMS not to reduce these pre-service times to zero and in the CMS CY 2018 Final Rule CMS agreed, stating, "…we do not believe that the standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes in future rulemaking."

In our comment letter on the proposed rule the RUC maintained that it is accurate to assume that no clinical staff time is necessary for minor procedures; however as more procedures are able to be performed without extensive follow-up it is no longer true that all 0 and 10-day globals can be classified as minor procedures. Additionally, in the past decade several complex procedures were implemented as 0-day procedures to allow flexibility for multiple clinicians on the care team to care for a patient without being limited by a 90-day global period.

The PE Subcommittee discussed that the language stating 0 minutes of pre-service time as a standard for 000 and 010 day globals should be broadened to allow for more variability. The PE Subcommittee will change the language around this issue to a presumption of zero minutes of pre-service clinical staff time. CMS stated that identifying 000 day globals that were previously 090, as some specialties have already done, is helpful. **The PE Subcommittee will change the language in the reference materials from a "standard of zero minutes" to a "presumption of zero minutes". Information about the amount of pre-service clinical staff time and a change from a 090 day global to a 000 or 010 day global should be captured in the PE SoR.**

- **Obtain vital signs clinical activity time standard**

In the CY 2018 NPRM, CMS proposed to change the standard for obtain vital signs to 5 minutes, rather than zero, three or 5 minutes as noted below. The Agency explained that this proposal was based on what they have noted as an upward trend in the recommended time associated with this task due to the addition of obtaining the patient's weight and height.

- Level 0 (no vital signs taken) = 0 minutes
- Level 1 (1-3 vitals) = 3 minutes
- Level 2 (4-6 vitals) = 5 minutes

In the CY 2018 Final Rule, CMS did not finalize their proposal to establish 5 minutes as the standard for clinical staff time to obtain vital signs, however CMS did finalize their proposal to assign 5 minutes of clinical staff time to obtain vital signs for all codes that include at least 1 minute previously assigned to the activity and has a breakdown of clinical staff time. Some members of the PE Subcommittee stated that 5 minutes is reasonable for specialties that rely heavily on vital signs; however they were skeptical that other specialties take 5 minutes to obtain vital signs if they are obtaining them at all. The Subcommittee discussed the possibility of reverting back to 1 or 2 minutes to obtain vital signs for all codes that included less than 3 minutes previously. There was some confusion about time based services that are generally billed

in multiple units (typically 3-4) on the same day. CMS assured the PE Subcommittee that this was accounted for in their analysis. Given the confusion about the current state of this clinical activity the PE Subcommittee decided to discuss the issue again at the April 2018 RUC meeting with full information and provide a comment to CMS in response to the proposed rule.

- **Equipment recommendations for scope systems**

In the CY 2018 NPRM, CMS did not finalize their proposal to create and price a single scope equipment code for each of the five categories previously identified: 1) rigid scope; 2) semi-rigid scope; 3) non-video flexible scope; 4) non-channeled flexible video scope; and 5) channeled flexible video scope and supported the RUC's recommendation to create scope equipment codes on a per-specialty basis for these five or more categories of scopes as applicable, as well as proper pricing for each scope. The PE Subcommittee also learned that a 6th category of disposable scopes exist.

CMS clarified that the way the scopes and accessories appear currently is acceptable; however it could be drastically improved. The Agency is interested in organizing the scopes in a more coherent and streamlined fashion then how they currently appear in the CMS direct input database. CMS requests that the PE Subcommittee develop a conceptual framework outlining the most frequently used scopes in each specialty and details on how physicians decide which scope is appropriate to use for any given procedure. **The PE Subcommittee will reconvene the previous Scope Systems and Endoscopes Workgroup, chaired by Doctor Barkley with members Doctors MacCormack, Cleveland and Sentovich to develop this framework.**

V. Exam Table Included in Services Performed in an Ultrasound Room

During the PE Subcommittee meeting the Subcommittee questioned if an exam table should ever be allocated to services performed in an ultrasound room. The ultrasound room includes an ultrasound table; however an exam table may be used in addition or for recovery. **Staff will conduct an analysis to find any services that included both an exam table and an ultrasound room. The PE Subcommittee will review this data at the April 2018 RUC meeting and determine if the tables are duplicative and whether or not the PE Subcommittee should recommend removing the exam table.**

VI. Other Business

During the PE Subcommittee meeting a service was reviewed were the specialty requested a large number of sanitizing wipes. Although this was appropriate, a member of the Subcommittee questioned if there is a need to develop cleaning packages. The Subcommittee determined that there was too great variation across specialties to develop packages and ultimately it was decided that no further action is needed.

Another PE Subcommittee member suggested review of the IV starter kit for accuracy and a standard for the circumstances when a desktop computer is included in direct practice expense inputs.

The Subcommittee then discussed potential improvements to the PE Subcommittee process including:

- Additional automation of the PE spreadsheet to detect duplication

- Email to all PE Subcommittee members of the revised PE materials, separated out from the handouts folder.
- Reiterating to the specialty societies to highlight changes in their spreadsheets (using yellow fill spreadsheet cells, red numbers).

Additionally, CMS emphasized that all revisions to the PE direct inputs in the PE spreadsheet should be reflected in a revised PE SoR. CMS prefers that all granular detail is included in the PE SoR and **not** on the PE spreadsheet. CMS continued that it is appropriate to include an explanation of each line item in the PE SoR. If a change to the PE spreadsheet is not included in the PE SoR CMS will assume that there is no justification for the inputs in the PE spreadsheet.

Practice Expense Recommendations for CPT 2019:

Tab	Title	PE Input Changes
4	Fine Needle Aspiration	No Change
5	Aortoventriculoplasty with Pulmonary Autograft	No Change
6	Hemi-Aortic Arch Replacement	No PE Inputs
7	Leadless Pacemaker Procedures	Modifications
8	Pulmonary Wireless Pressure Sensor Service	Modifications
9	PICC Line Procedures	Modifications
10	Biopsy or Excision of Inguinofemoral Node(s)	No Change
11	Gastrostomy Tube Replacement	Modifications
12	Dilation of Urinary Tract	Modifications
13	Water Vapor or Steam Thermotherapy	Modifications
14	Ultrasound Elastography	Modifications

Tab	Title	PE Input Changes
15	Contrast-Enhanced Ultrasound	Modifications
16	Magnetic Resonance Elastography	No Change
17	Electroretinography	Modifications
18	Electrocorticography	No PE Inputs
19	Psychological or Neuro-psychological Test Administration	Modifications
20	Chronic Care Remote Physiologic Monitoring	Modifications
21	Interprofessional Internet Consultation	No PE Inputs
22	Exploration of Artery/Vein	No Change
23	Radioactive Tracer	Modifications
24	Hemorrhoid Injection	Modifications
25	Dual-energy X-Ray Absorptiometry (DXA)	Modifications
26	Fibrinolysins Screen	No PE Inputs
27	Cardiac Output Measurement	No PE Inputs
28	Peripheral Artery Disease (PAD) Rehabilitation (PE Only)	Modifications

AMA/Specialty Society RVS Update Committee **Tab 30**
Administrative Subcommittee
January 11, 2018

Members: Doctors Walter Larimore (Chair), Gregory DeMeo (Vice Chair), Michael Bishop, Ronald Burd, Jeffrey Edelstein, William Fox, Michael Gerardi, Eileen Moynihan, Guy Orangio, Julia Pillsbury, Adam Rubin, Marc Raphaelson, Eugene Sherman, Karen Smith, RD, Norman Smith, Michael Sutherland, James Waldorf, David Wilkinson.

I. Review Rotating Seat Election Rules and Candidates Nominated (Tab 36)

The Administrative Subcommittee reviewed the nomination for the primary care rotating seat, Jennifer Aloff, MD from the American Academy of Family Physicians and determined she met the primary care rotating seat qualifications. The Subcommittee also reviewed the nominations for the internal medicine rotating seat, Jonathan Leffert, MD American Association of Clinical Endocrinologists and Daniel McQuillen, MD, Infectious Diseases Society of America. The Subcommittee noted that "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote."

II. Low Survey Responses/Contractor Pricing

At the October 2017 RUC meeting, a RUC member requested that the Administrative Subcommittee discuss whether codes that have a very low response rates (under 30) should automatically be recommended for contractor pricing.

AMA staff compiled a list of all the services surveyed in the last five years that had a survey response below the minimum threshold of 30 responses with information on what the RUC recommendation was based on (ie, survey data point, crosswalk or maintained existing work RVU). The result was 28 services.

- Only 3 of these services have a utilization over 10,000
- Over half of these recommendations were not based on the survey data (15 of 28)
- CMS accepted 15 of the 28 RUC recommendations for these services (not the same services in the above bullet point)

The Administrative Subcommittee reviewed the history of low survey responses and determined that the RUC should not automatically recommend contractor pricing codes that have a low response rate (under 30), but continue its current process and review each unique code set individually. The Subcommittee indicated that its main concern is that new Category I CPT codes are created when in reality the services are not widely performed and a valid survey with 30 responses is not obtainable. **The Administrative Subcommittee recommends that the RUC flag new Category I services with a survey response below 30 to be reviewed in three years by the Relativity Assessment Workgroup. Specialty societies will submit an action plan indicating whether these services should be resurveyed or referred to the CPT Editorial Panel for deletion or revision to a Category III code.**

AMA/Specialty Society RVS Update Committee **Tab 31**
Relativity Assessment Workgroup
January 11, 2018

Members: Doctors Scott Collins (Chair), George Williams (Vice-Chair), Amr Abouleish, James Blankenship, William Donovan, Matthew Grierson, David Hitzeman, Gwenn Jackson, John Lanza, Charles Mabry, Daniel Nagle, Dee Adams Nikjeh, PhD, Scott Oates, Holly Stanley and Edward Vates.

I. Re-Review of Services – Action Plan Review (76942)

Throughout the RUC's review of potentially misvalued services, codes have been flagged for review at later date after additional utilization was available, CPT assistant articles were published or additional information was gathered.

In April 2014, the RUC noted that CMS identified 76942 as being potentially misvalued in the 2014 NPRM because of the high frequency that it is billed with CPT code 20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa), which has a shorter clinical staff intra-service time than the ultrasound guidance procedure. In response, the specialty societies created a bundled code for arthrocentesis performed with ultrasound guidance, CPT code 20611, which was a new service in CY2015. As the expected billing pattern for 76942 as a stand-alone service is unknown, the RUC agreed to monitor the future utilization of 76942 to ensure that the services commonly billed with it do not include clinical staff times which is non-congruent with the clinical staff times of the ultrasound guidance service. In October 2015, this service was also identified under the high volume growth screen and the RUC noted to review the utilization in October 2017. In October 2017, this code appeared on an agenda tab but it was not surveyed. Therefore, the RUC indicated that this service was not addressed via this flag because the RAW thought it was going to be addressed from the RUC survey process. The RUC recommended that the specialty societies should submit an action plan to address the growth in utilization for these services for the January 2018 meeting.

The Workgroup reviewed this issue and noted that this service was recently bundled in 2015 and the clinical staff time is not duplicative, utilization of this service is going down. **The Workgroup recommends maintaining CPT code 76942 and complete for this screen.**

II. Surveyed by One Specialty, Now Performed by a Different Specialty – Action Plan Review (11981, 20225, 62270, 62368, 64590, 97598)

AMA Staff re-examined services that were surveyed by one specialty and are now performed by a different specialty based on 2016 Medicare utilization over 1,000. The Relativity Assessment Workgroup recommended action plans for codes 11981, 20225, 62270, 62368, 64590, 97598 to review in greater detail at the January 2018 Relativity Assessment Workgroup meeting.

CPT Code	Recommendation
11981 11980 (f) 11982 (f)	Refer to CPT to better define these services and differentiate between the use in musculoskeletal procedures and use in urological or gynecological procedures. May 2018 CPT or Oct 2018 CPT.
20225	Survey for 2020 cycle.
62270	Refer to CPT to bundle with 77003 and maintain the code without fluoroscopic guidance, for CPT 2020.

62368 62367 (f) 62369 (f) 62370 (f)	Review the direct PE inputs (specifically clinical staff time) for this family of services in April 2018. Maintain the work RVUs.
64590	Refer to CPT for revision to properly describe the service as performed by urology.
97598 97597 (f)	Survey April 2018. Specialty societies may determine to revise descriptor at CPT or revise 97598 to be an add-on service.

III. CMS/Other Source – Utilization over 30,000 – Action Plan Review (34 services)

In April 2017, the Relativity Assessment Workgroup noted that the RUC has identified and reviewed CMS/Other Source codes with utilization 100,000 or more and noted that the Harvard-Valued services with 30,000 have been reviewed. The Workgroup requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more and review at the October 2017 meeting. This list resulted in 34 services.

The Workgroup reviewed the action plans in detail and noted that crosswalks to similar radiology services with low physician time and work RVUs are appropriate as a resurvey would not result in much variation. **The Workgroup indicated that the specialty societies must bring the crosswalk request to the Research Subcommittee for approval since it not a random survey.** The Workgroup noted that the Research Subcommittee previously approved this methodology.

The Workgroup questioned why the specialty societies were recommending crosswalks for some of the radiology services but surveys for other radiology services. The specialty societies indicated and the Workgroup agreed that cross-walking codes in which recent surveys were conducted for services of the same body region, similar times, and work RVUs are appropriate. Some upper extremity services were not recently surveyed therefore, the specialty society indicated that they should survey these as there is not a recent upper extremity crosswalk.

CPT Code	Recommendation
70210 70220	Crosswalk like other recent similar radiology recommendations. April 2018.
70250 70260 (f)	Crosswalk like other recent similar radiology recommendations. April 2018.
70360	Crosswalk like other recent similar radiology recommendations. April 2018.
70480 70481 (f) 70482 (f)	Survey for October 2018.
72132 72131 (f) 72133 (f)	Survey for April 2018.
72190 72170 (f)	Crosswalk like other recent similar radiology recommendations. April 2018.
73000 73010 73020 73030 (f) 73050 (f)	Survey for April 2018.

CPT Code	Recommendation
73701 73700 (f) 73702 (f)	Survey for April 2018.
74240 74241 (f) 74245 (f) 74246 74247 (f) 74249 (f)	Refer to CPT May 2018 to revise to condense this family of services and combine fluoroscopy.
74250 74251 (f) 74260 (f) 74270 74280 (f)	Refer to CPT May 2018 to revise to condense this family of services and combine fluoroscopy.
75625 75630 (f)	Survey October 2018.
75726 75774	Survey October 2018.
76098	Survey April 2018.
76604	Survey April 2018.
77073 77074 (f) 77075 77076 (f) 77077	Survey April 2018.
88141	Survey April 2018.
92585	Refer to Feb 2019 CPT meeting to clarify the code descriptors to better define limited/comprehensive and develop a new related procedure, Vestibular Evoked Myogenic Potentials (VEMP), has recently been approved by the FDA. A VEMP specific code should be developed and will replace some use of CPT code 92585.
94200	Survey April 2018. The specialty societies can determine if they want to revise at CPT and should identify other codes that are part of this family.
95831 95832 (f) 95833 (f) 95834 (f)	Defer to April 2018. The Workgroup requests action plans on how to address 95831-95894. The specialty indicated that CPT code 95831should be considered services provided as part of an E/M. Each of the four codes in this family is primarily performed by different specialties. PT and Neurology agreed with the recommendation to delete code 95831 as it is probably being reported inappropriately. It appears a few providers in one state are primarily performing this service. The Workgroup will review this data in April 2018, with requested input from all societies that are primary utilizers within this code set.
G0124	Survey April 2018
G0279	Recommend CMS delete G0279 and use CPT codes 77061 and 77062 to report these services.
G0364	Deleted. New CPT code 38222 replaced G0364 for 2018.
G0365	Refer to CPT to convert to Category I code. CPT cycle 2020.

CPT Code	Recommendation
G0396	Maintain and Refer to CPT to change editorially remove "screening" from 99408 and 99409 to "assessment" to mirror G0396.
G0446	Survey April 2018.
G6002	Maintain. Specialty societies continue to work with CMS to cover Category I codes to report these services.

IV. Reported Together 75% or More – Action Plan Review (4 issues)

Maintaining the consistency with previous iterations, AMA staff used the 2015 Medicare 5% sample claims data to determine when a code pair is reported on the same day, same patient and same NPI number at or more than 75% of the time. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in Medicare claims data and/or contained at least one ZZZ global service were removed. Based on these criteria four groups were identified (93503/36620, 32405/77012, 66711/66984, and 45381/45385). **The Workgroup reviewed the action plans for these services and recommends:**

CPT Codes	Recommendation
93503/36620	Maintain. These services were just reviewed in October 2016. These are two separate procedures that do not have overlap in work and do not directly contribute to each other. Thus, are not appropriate to be bundled together.
32405/77012	Refer to CPT to bundle. CPT 2020.
66711/66984	Refer to CPT to bundle or create add-on code. CPT 2020.
45381/45385	Maintain. The GI endoscopy codes reflect only the work involved in the procedure described. Therefore, if several procedures from the same endoscopy family are required and are performed during the same session, only the work of each individual procedure is captured. Because of application of the increment to physician work and the use of the multiple endoscopy reporting rule, there is no work or time overlap for individual procedures within the GI endoscopy families.

V. Work Neutrality (CPT 2016) – Action Plan Review (Intravascular Ultrasound 37252 & 37253)

Each year AMA staff reviews the utilization assumptions for work neutrality when the Medicare Utilization data for that year/cycle is available. Any code family that has an increase in work RVUs over 10% of what was estimated is reviewed by the RAW to determine what is occurring. Intravascular Ultrasound, CPT codes 37252 and 37253 that were reviewed at the January 2015 meeting and assumed to be a savings is actually a 44% increase in work RVUs from the old codes in 2015 to 2016 and the utilization was double from that of the coding structure, not even taking into account the radiological activities.

These codes were originally nominated by CMS via the NPRM for 2015 MPFS, where a stakeholder requested that CMS establish non-facility PE RVUs for CPT code 37250 and 37251. CMS sought comment regarding whether it was appropriate to have non-facility PE RVUs for these codes and if so what inputs should be assigned. In September 2014 the RUC recommended to refer this issue to CPT. At the October 2014 CPT meeting, CPT codes 37250 and 37251 were deleted and new bundled codes were developed to describe Intravascular Ultrasound (IVUS).

On another note, in the October 2016 CPT code change application that SIR and SVS submitted for CPT 2018 book, the specialties asserted that payers have been rejecting claims for code pairs that were previously and appropriately allowed. The resulting parenthetical added for 2018 includes a list of over 175 codes that may be reported in conjunction with 37252 and 37253. At the time of the proposal AMA staff did not have the 2016 Medicare utilization data to identify there was already a doubling of utilization for these services. Clearly claims were not being denied and going forward with the multitude of codes that 37252 and 37253 may now be reported with it will most likely explode.

The pricing for the IVUS catheter $1,025 is what drives the overall PE RVUs. For CPT Code 37252, the 2018 non-facility PE RVUs are 36.65, with total non-facility RVUs of 38.83 or total 2018 non-facility Medicare payment of $1,397.86. The IVUS catheter invoices supplied from Volcano Corporation were $975 and $1,050, which were submitted at the January 2015 RUC meeting and subsequently submitted to CMS on February 9, 2015. On February 17, 2015, Philips acquired Volcano Corporation. Currently, Philips and Boston Scientific have the majority of the market share for this IVUS catheter.

The specialties that surveyed these codes in 2015 were ACC, SCAI, SIR and SVS. **These specialty societies indicated and the Workgroup agreed to review in April 2018 after reported together data is available. The Workgroup noted that its main concern with this family is regarding the practice expense inputs in the physician office.**

VI. Low IWPUT (Informational Only)

In April 2017, the Relativity Assessment Workgroup discussed expanding a potentially misvalued services screen to those services with low IWPUT. The Workgroup noted that the 0.0224 is the IWPUT for pre-evaluation, pre-positioning and immediate post-service time. The Workgroup requested AMA staff to compile a list of all services with an IWPUT of 0.0224 or lower, which resulted in 161 services. In October 2017, the Workgroup determined that it would like to pare down the data to better assess whether this is an appropriate screen.

- 010 and 090 day global codes only
- IWPUT below 0.0224
- Utilization over 30,000
- Intra-service time greater than 15 minutes
- RUC reviewed more than 5 years ago
- Greater than zero pre and post service time (did not need to apply after the above criteria were applied)

AMA staff ran the above criteria and no services were identified. Therefore, the Workgroup will not continue with this as an appropriate screen.

VII. Informational Items

The following documents were filed as informational items: Referrals to the CPT Editorial Panel; Referrals to the CPT Assistant Editorial Review Board; Potentially Misvalued Services Progress Report and CMS/Relativity Assessment Status Report.

VIII. New Business

Review codes on the -51 modifier exempt list to make sure there is no duplication on pre- and post- work related to the services it is typically reported.

AMA/Specialty Society RVS Update Committee **Tab 32**
Professional Liability Insurance (PLI) Workgroup Meeting
January 11, 2018

Members Present: Doctors James Blankenship (Chair), Jennifer Wiler (Vice Chair), Ronald Burd, Stephen Chan, Joseph Cleveland, William Gee, Michael Gerardi, Gwenn Jackson, Walt Larimore, Eileen Moynihan, Scott Oates, Daniel Nagle, Michael Sutherland, David Wilkinson, Stanley Stead, Doris Tomer, LCSW

CMS Participants: Marge Watchorn, Karen Nakano, MD, Michael Soracoe, Ryan Howe, Tourette Jackson, Geri Mondowney, Patrick Sartini, Kathleen Kersell, Kathy Bryant

Acumen Participants: Michael Collier, Nirmal Choradia, and Nicole Sowers

I. PLI Premium Data Collection

Representatives from Acumen and CMS attended the meeting via teleconference to discuss recent premium data collection efforts by Acumen on behalf of CMS. The RUC in October had expressed strong concerns that CMS should be able to obtain premium information for all Medicare physician specialties, and other health care professionals.

Acumen explained that PLI premium data was collected for 32 states using the System for Electronic Rate and Form Filing (SERFF) Filing Access Interface. For states that do not participate in the SERFF Filing Access Interface, Acumen contacted state departments of insurance and requested medical malpractice rate filings. Using these methods, a total of 7,212 raw rate filings from all 50 states, D.C., and Puerto Rico were received. This was an improvement on the CY 2015 update, which used 3,473 raw rate filings. The number of specialties with sufficient data to meet the 35 state thresholds in the CY 2018 update was similar to prior years: 44 specialties in the CY2010 update, 41 specialties in the CY 2015 update, and 43 specialties for the CY 2018 update. (Specialties for which data cannot be obtained from 35 states are attributed premium data by cross-walking to other specialties based on the data which is available.) The workgroup questioned the threshold of 35 states and CMS stated that they adhere to a historical precedent by using 35 states, and felt that a lower threshold would not significantly decrease the number of specialties requiring a cross-walk.

CMS and Acumen representatives explained that in the CY2018 proposed rule, the reason that certain specialties, like Cardiology, did not have sufficient data to compute separate surgical and non-surgical risk factors was directly due to how the raw rate filings were categorized, rather than to data availability itself. CMS and Acumen acknowledged that there are many rate filings that do not necessarily map cleanly to one single specialty. They presented an alternative option to count select raw rate filings toward the risk factor calculations for multiple related specialties in cases where several specialties are applicable. The workgroup agreed that it would make sense to consider including a single rate filing in the risk factor calculations for multiple specialties and also offered to help with the categorization process.

Significant discussion focused around the PLI RVU methodology and suggestions for refinements to more accurately reflect risk and premium costs of physicians. The workgroup believes that the real expense of professional liability costs may not be captured by the current methodology. CMS emphasized its limited resources, questioned the cost-benefit of changing the entire methodology, and suggested that

putting resources into additional data collection might be where the best benefit lies. They also recognized that the work RVU reflects PLI in its measure of intensity that is tied to risk.

Further discussion involved the collection of PLI premium data on non-physician providers (NPP) who now comprise 20% of allowed charges within the Physician Fee Schedule. The RUC has long raised concerns that by crosswalking to the specialty of Allergy and Immunology (which has the lowest premiums of any specialty); the PLI is overestimated for non-MD/DOs. Acumen noted that adequate premium data was obtained for some non-MD/DOs or other health care professionals (eg, CRNAs and nurse-midwives) but could not explain why insufficient data was collected for most other non-MD/DO professions. AMA staff referenced an insurance carrier, Health Providers Service Organization (HPSO) www.hpso.com, as a source of potential information for collection of premium data for most non-MD/DOs.

Other suggestions from the workgroup for obtaining better data included the following:

- Work with large medical groups/systems whose physicians do not pay individual premiums, but where the costs of malpractice insurance for different specialties within their group/system are known.
- Obtain data on malpractice premiums directly from physicians and other providers by survey, or by required reporting to CMS. CMS commented that, given the current regulatory environment, it is hard to imagine that imposing a large data collection requirement on physicians is realistic
- Contact large malpractice insurance carriers to obtain data on PLI premiums for physicians they insure. Workgroup members have identified one such company that offered to provide such data and work with CMS to obtain similar data from other companies.

The workgroup offered to help CMS with the multi-layered crosswalks or in any other way at the request of CMS. The PLI workgroup appreciates that CMS is willing to refine certain aspects of the data collection methodology, as demonstrated by the CY2018 final rule where the updated PLI premium data were not finalized after problems with it were pointed out by the RUC and other commenters. **The workgroup will develop a letter to CMS with suggested improvements to data collection and classification. A conference call will be planned for March to review and finalize the letter for approval by the RUC in April 2018.**

II. Codes Missing from Low Volume PLI Recommendations

There were some codes missing from the list of Expected Specialty Recommendations for Low Volume Services submitted to CMS with RUC's proposed rule recommendations. The original RUC PLI analysis was based on the Medicare payment status for the global setting, whereas there are a few codes that only have their 26 modifier covered. As a result, an additional 28 codes were identified that should be included on the list. The Workgroup was asked to review and approve the additional list of expected/anticipated specialties for low volume services. Specialty society input was solicited to fill in the recommendations for these codes.

The PLI Workgroup unanimously approved the worksheet of Codes Missing from the list of Expected Specialty Recommendations for Low Volume Codes. The RUC will submit recommendations for expected specialties for these codes with the February recommendations.

Members Present: Margie Andreae, MD (Chair), Gregory Przybylski, MD (Vice Chair), Allan Anderson, MD, Robert Dale Blasier, MD, Jimmy Clark, MD, Verdi DiSesa, MD, Peter Hollmann, MD, Katie Jordan, OTD, OTR/L, Timothy Laing, MD, Alan Lazaroff, MD, M. Douglas Leahy, MD, Daniel McQuillen, MD, Timothy Tillo, DPM, Christopher Senkowski, MD, Robert Zwolak, MD

I. Minutes, October 5, 2017 RSC Specialty Requests In-Person and Subsequent Electronic Review

The Research Subcommittee report from the October 2017 in-person meeting and subsequent electronic review included in Tab 33 of the January 2018 agenda materials was approved without modification.

II. Review of Specialty Requests *(new items)*

a. Transcatheter Aortic Valve Replacement (TAVR)

At the October 2017 RUC meeting, the specialty societies involved requested that the TAVR family of codes be tabled and sent to the Research Subcommittee to develop a reliable methodology to value this unique set of services which are currently mandated by a national coverage determination (NCD) to include the participation of two physicians and use of modifier 62. The specialties outlined their concerns with valuing these codes using the current methodology during the discussion with the pre-facilitation committee and the RUC. These are currently the only codes in the fee schedule where the -62 co-surgeon modifier is required 100 percent of the time. As each co-surgeon receives 62.5% of the work value and each is performing the service and post-operative visit concurrently, this requirement may impact valuation and interpretation of code components (various types of work per unit time; time spent by each provider) making accurate value determination difficult. Furthermore, the specialties noted that the Research Subcommittee and the RUC had previously approved the TVT registry as an extant data source and it was unclear to the specialty societies how specifically these data points would be used in conjunction with the RUC survey data.

In October 2017, the RUC agreed to take no action on these codes and table their review until the April 2018 RUC meeting to provide the specialties and the Research Subcommittee sufficient time to resolve these methodologic issues. During the RUC's October 2017 other business discussion, the RUC agreed that specialties must provide both median and mean for extant data sources as these summary data would provide the RUC with a more complete picture of central tendency. Providing both median and mean would provide information as to whether the dataset is negatively or positively skewed and to what degree.

Prior to the January 2018 RUC meeting, the specialty societies submitted a letter with a series of questions to be discussed by the Research Subcommittee. At the January 2018 Research Subcommittee meeting, the Subcommittee had a discussion with presenters from the Society of Thoracic Surgeons (STS), American College of Cardiology (ACC), American Association for Thoracic Surgery (AATS) and the Society for Cardiovascular Angiography and Interventions (SCAI) addressing their questions.

During the discussion, the specialties noted that there has been a move to retire the NCD that mandates co-physicians for TAVR services, so there is a possibility that the NCD requirement

could go away sometime in the future. (AMA Staff Note: The current CPT introductory language also states that "TAVR/TAVI requires two physician operators and all components of the procedure are reported using the 62 modifier.")

The societies proposed the idea of making an adjustment to the survey instrument or to the resultant survey data to directly account for the 62 modifier payment adjustment (ie. increasing the value of all of the reference service codes to align with the change in payment due to the modifier or transform the survey data work RVUs to account for payment policy). The Subcommittee expressed strong reservation with making any adjustment to either the survey instrument itself or to the survey RVU summary data. The Subcommittee noted that there is no existing precedent for making survey modifications based on Medicare payment policy. **The Research Subcommittee did not approve any modification to the survey instrument or the survey data to simulate the payment adjustment created by the 62 co-surgeon modifier.** The Subcommittee did note that that the specialties after following standard RUC survey process may provide additional rationale to support their recommendation. One idea suggested was to provide an adjusted IWPUT to account for the reduction (ie reducing the IWPUT by 37.5% to adjust for the payment policy) in addition to the standard IWPUT based on the survey. The specialties had also asked for comment on conducting a survey where the co-physicians were not required to complete the survey side-by-side and the Subcommittee noted that this was not a RUC requirement and therefore could not comment.

In discussing use of the extant database, the Subcommittee noted that, at the October 2016 RUC meeting, the Time and Intensity Workgroup recommended and the RUC approved that "*If a specialty has a RUC-approved source of extant physician time data, then that Specialty can use this methodology as supporting evidence for their RUC recommendation, though they would still be required to conduct a RUC survey*." The Subcommittee clarified that because the current RUC database is based predominantly on survey data, it is important to continue to use survey data to maintain relativity across services. While a data source that is based predominantly on measured data may be more accurate, it creates challenges with relativity. **The Research Subcommittee recommends for the RUC to continue to require a RUC survey and presentation of survey data when data from a RUC-approved extant database is also available. The Subcommittee noted that data from the RUC-approved extant database may be used to support the advisory committees' recommendation.**

The Subcommittee also discussed use of mean versus median summary data. The Subcommittee noted that both the mean and the median values provide different useful information. **The Research Subcommittee recommends for the RUC to continue requiring both the mean and the median physician times drawn from a RUC-approved extant database.** The Subcommittee noted that the specialties may provide rationale on why one value is preferable to another on a case-by-case basis. The Subcommittee clarified that it is not within their purview to indicate how the RUC will use data.

III. RUC Crosswalk Recommendations *(new item)*

At the October 2017 meeting, the RUC referred a request to Research Subcommittee to review the RUC's recent usage of crosswalk codes and whether further rules/guidelines are necessary. The RUC requested for AMA staff to perform an analysis of previous RUC recommendations based on crosswalks. AMA staff analyzed 468 codes from the past 6 RUC/HCPAC meetings. 104 (22%) of these recommendations were based on a crosswalk. When the RUC recommendation was based on a crosswalk code, the RUC always recommended an identical work RVU. In addition, both services had identical global period assignments 95% of the time. A

significant number of the codes (79% intra-time and 60% total-time), the RUC recommended time was within 10% of the time for the crosswalk code. Nearly every crosswalk code selected had been reviewed by the RUC (98%).

The Chair noted that the crosswalk methodology is used in several ways:

- Following when a service is sent to a facilitation committee
- Crosswalk in lieu of a survey though this first requires Research approval (ie several X-ray codes in the past two years)
- When survey data is either deemed incorrect or invalid

After review of the analysis prepared by AMA staff, the Subcommittee concluded that the RUC has an excellent track record over the past two years of selecting appropriate crosswalks and no defined guidelines are indicated. **The Research Subcommittee requested for AMA staff to conduct this analysis again in two years for the Subcommittee's review.**

IV. 000-day Global Codes Typically Billed with E/M Services *(continued from Oct 2017 RSC Meeting)*

At the April 2017 RUC meeting, during *Other Business,* a RUC member requested that methodological issues related to procedure with 000-day global typically billed with E/M be referred to the Research Subcommittee. The RUC has identified codes that are typically reported with E/M on the same date to ensure that there is no duplication of pre and post work. The member requested review to ensure that there was greater standardization approach to pre and post work identified for the 000 day global procedures that are deemed to be above and beyond the E/M reported on that same date.

AMA staff performed an analysis of existing codes from the past four RUC meetings to illustrate pre and post modifications made to procedures with 000-day global period assignments.

One Subcommittee member suggested that in their view, they did not think that there should be any additional pre-service evaluation time for a procedure if it was inherently performed (75% of time or more) on the same date as an E/M. Other Subcommittee members did not agree with this assertion and noted that there is evaluation time for the procedure that goes above and beyond the E/M performed on the same date. The Subcommittee agreed to continue this discussion in April 2018. Staff will provide a table with the procedure codes with a 000 day global period that are performed with E/M 75% of the time or more, along with the pre-evaluation time for these services.

It was noted, that the current survey instrument instructions for 000 day procedures include the following language related to pre-service time:

> ***Pre-service period***
> *The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:*
>
> • *Hospital admission work-up.*

• The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.

• Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient and other "non-skin-to-skin" work in the OR.

*The following services are **not included**:*

- *Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).*
- *Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).*
- *Mandated services (reported with modifier -32).*
- *Moderate (conscious) sedation services (reported with CPT codes 99151-99157).*

The Research Subcommittee requested for AMA staff to work with several volunteers from the Subcommittee to ensure that the RUC survey instructions are clear on the exclusion of time for evaluation otherwise included in the same-day E/M. Proposed revisions will be considered at the April 2018 RUC meeting.

V. Standard Survey Language Solutions for Time-Based Codes *(continued from Oct 2017 RSC Meeting)*

Following the June 2017 Research Subcommittee conference call, a member recommended that the Subcommittee discuss potential standard solutions for surveying time based codes. In the past, certain time based codes have had custom question pertaining to the typical number of units of the code and/or pertaining to the total time involved in performing the service added to the survey. Specialties have also employed custom disclaimer text throughout the survey templates and survey distribution emails. Bolding and underlying text has also been utilized.

At the October 2017 meeting, the Research Subcommittee noted that recently it has been somewhat common for the HCPAC to review time-based CPT Codes and that valuing these services has proven somewhat difficult. Currently, on a case by case basis, specialties have proposed custom survey language to capture the amount of time units a service typically takes. Members suggested having survey language options available to societies may simplify their efforts when clarifying their surveys. The Research Subcommittee requested for AMA Staff to assemble examples of language used in the past and also noted that they would continue discussing this issue at the January 2018 meeting.

At the January 2018 meeting, the Subcommittee reviewed custom language recently used for time-based codes as well as the following language drafted by AMA Staff:

1) ***For a base code/add-on code pair:***
For the typical patient, how much total time do you personally spend performing this entire service from start to finish ([based code] and all increments of [add-on code])? **Please answer in minutes.** *Note, the intent of this question is to determine the typical number of units you would report for these time-based survey codes by measuring the full length of time it typically takes for you to perform the service described.*
Total Time in Minutes ***(which may correspond with multiple units of the survey codes)*:**

2) ***For a per-unit of time survey code:***
For the typical patient, how much total time do you personally spend performing this entire service from start to finish (which may correspond with multiple units of time-based code [survey code])? **Please answer in minutes.** *Note, the intent of this question is to determine the typical number of units you would report for the time-based survey code by measuring the full length of time it typically takes for you to perform the service described.*
Total Time in Minutes ***(which may correspond with multiple units of the survey code)*****:**

The Subcommittee expressed some interest in using some version of the proposed draft language. A Subcommittee member inquired whether it may be more appropriate to instead directly ask the respondent to estimate the units of the code that they would typically report. AMA staff noted that their rationale for keeping the question related to total time, instead of units of service, was so that the survey respondents would not need to have a complete understanding of the sometimes complex rules for reporting time-based codes. **The Research Subcommittee requested for AMA staff to draft a standard sample survey instrument for time-based codes for the April 2018 meeting.**

VI. Typical Vignettes Analysis by AMA Staff *(continued from Oct 2017 RSC Meeting)*

At the October 2017 meeting, the Research Subcommittee agreed upon prominent instructions stating that survey respondents should value the services based on the provided typical patient. The Research Subcommittee also requested for AMA Staff to perform an analysis for the January 2018 RUC Meeting regarding how often survey codes that received RUC recommendations had less than 50 percent agreement with the provided vignette. AMA staff provided an analysis of all final recommendations submitted to CMS from the past 6 meetings. The analysis only included data from codes that had RUC recommended value (ie data from services referred to CPT were excluded). The analysis showed that 96 percent of the codes reviewed over the past 6 meetings had over 70 percent of respondents indicate that the provided vignette was their typical patient. After reviewing the data provided by AMA staff, the Subcommittee agreed that the vignettes included in recent surveys represent the typical patient for the vast majority of survey respondents and no concerns were validated. The Subcommittee also noted that recent new language was added to the surveys to instruct the respondent to base their selections on the patient in the vignette even if they did not agree that this was their typical patient.

VII. Other Business:
Minutes from December 4, 2017 Ad Hoc Pre/Post Time Package Workgroup Conference Call (Informational)

The Research Subcommittee has charged the Ad Hoc Workgroup with reviewing the existing pre-service and post-service time packages and recommended new and revised time packages if deemed necessary. The Chair of the Ad Hoc Workgroup provided a brief overview of the topics discussed on the call, including how to define a complex patient, whether the current packages need to be updated and also how to create non-facility post-service time packages. The Workgroup requested for AMA staff to provide several analyses, including an analysis with the 25th percentile, median and 75th percentile pre- and post-service times, a comparison between the survey times and the final RUC recommendations for the past few meetings. The Workgroup also requested for AMA staff to provide more detailed history on how the current times were assigned to the packages. The Workgroup will schedule another call prior to the April 2018 RUC meeting.

AMA/Specialty Society RVS Update Committee **Tab 34**
Anesthesia Workgroup
January 12, 2018

Members: Doctors Verdi DiSesa (Chair), Dale Blasier (Vice Chair), Scott Collins, William Donovan, Christopher Senkowski, James Waldorf, Thomas Weida, George Williams and Robert Zwolak.

I. Validate 2007 Methodology

At the October 2017 Anesthesia Workgroup meeting, the Workgroup determined that before it can reliably value anesthesia codes it must first validate a methodology to identify a set of anchor or reference codes. At this meeting the specialty society was asked to update and explain the 2007 methodology last used for this purpose. AMA staff noted that 8 of the top 32 anesthesia codes have a single surgical code that is reported at least 50% of the time with the anesthesia code. The Workgroup requested that the specialty society review the 2007 methodology and confirm or revise the methodology using the 8 codes as an example.

The American Society of Anesthesiologists (ASA) presented the 2007 building block methodology updated with 2018 data and some new assumptions. The Workgroup determined that it would not be appropriate to use the building block method to develop recommendations for valuation of anesthesia services. However, this methodology, suitably modified, may be useful to demonstrate relativity between anesthesia services and to establish a set of reference codes that may be used to establish a magnitude estimation survey of base units. The Workgroup discussed and thereafter requested that ASA review and revise elements of the building block methodology discussed at the meeting and including, but not limited to:

- Pre-service evaluation time – revise codes with a base unit of 16-30 which are referenced to code 99252 *Inpatient consultation for a new or established patient* (work RVU=1.50) since this service is considered "invalid" under the MFS.
- Provide more granularity and greater consistency among the categorization of codes within each step in the methodology and review current definitions for the surgical code pre and post categories in order to determine if there is a similar structure that may be used. For example, in the present version of the building block methodology, the pre-service evaluation times currently are divided into 4 groups based on base unit values of 3, 4, 5-15 and 16-30. These categories may not provide sufficient granularity at the higher values and vary from other steps in the process and therefore may not represent the most appropriate way to categorize these data.
- Equipment, drug and supply preparation – revise the base RVU assumption which currently includes a comparison to CPT code 99157 *Moderate sedation* (IWPUT 0.0833) as this has a high value compared to standard scrub, dress and wait intensity of 0.0081 which was used in the 2007 methodology .
- Members of the Workgroup and the representatives of the specialty society were encouraged to propose other refinements to the proposed building block methodology and to incorporate them in a refined proposal to be presented at the April 2018 meeting.

The Workgroup also discussed the pitfalls of attempting to develop a methodology for comparing anesthesia base units to physician work RVUs. After some discussion, the Workgroup determined that it would focus on defining a method to determine relativity between anesthesia services compared to other anesthesia services. Given the relatively few degrees of freedom inherent in the Congressionally-mandated system of anesthesia base units, the Workgroup thought it unnecessary at this time to develop a technique for the precise determination of relativity between anesthesia base codes and work units of all other physician services.

The Workgroup supports the concept of attempting to devise a refined building block methodology which would be used to construct an anesthesia reference service list to be used to develop appropriate base units for anesthesia services. The Workgroup requested that the ASA incorporate the suggestions of the Workgroup to refine the building block method and to apply this method for discussion at the next Workgroup meeting, to the same 8 anesthesia codes presented at this meeting.

II. Review analysis comparing the physician work component of anesthesia base units to work RVUs – Top 5 surgical services provided for each anesthesia code

The Workgroup had requested that AMA staff gather the top 5 surgical services for each of the top 32 anesthesia codes and display the surgical codes IWPUT compared to the Post-Induction Period Procedure Anesthesia (PIPPA) of the anesthesia codes for review at the January 2018 Workgroup meeting. The Workgroup had a brief discussion of these data without articulating the specific ways in which they might be used.

In April 2018, the Anesthesia Workgroup will review ASA's revised building block methodology assumptions for the 8 codes as a first step in developing an anesthesia reference service list. The Workgroup requested that staff schedule a 2-3 hour meeting of the Workgroup at the April 2018 RUC meeting in order to allow adequate time to discuss these complex issues.

AMA/Specialty Society RVS Update Committee **Tab 35**
Health Care Professionals Advisory Committee Review Board
Friday, January 12, 2018

Members Present: Michael Bishop, MD (Chair), Dee Adams Nikjeh, PhD, CCC-SLP (Co-Chair), Timothy Tillo, DPM (Alt. Co-Chair), Margie Andreae, MD, Charles Fitzpatrick, OD, Stephen Gillaspy, PhD, Anthony Hamm, DC, Peter Hollmann, MD, Katie Jordan, OTD, OTR/L, Folusho Ogunfiditimi, PA-C, Paul Pessis, AuD, Randy Phelps, PhD, Rick Rausch, PT, W. Bryan Sims, DNP, APRN-BC, FNP, Karen Smith MS, MBA, RD, LD, FADA, Doris Tomer, LCSW

I. Introductions

Dr. Nikjeh called the meeting to order at 8:00 am. Dr. Nikjeh reminded the Review Board of materials previously distributed by AMA staff describing RUC and HCPAC processes and policies that will be discussed during the meeting.

II. CMS Update

Doctor Edith Hambrick from CMS attended the HCPAC meeting and gave the HCPAC an update on recent activities at the Agency. There was a hearing recently to appoint a new head of HHS and we will know soon if that is approved. If any specialty societies or individuals plan to meet with CMS regarding the CY 2019 proposed rule they should do so now.

III. HCPAC Process and Policy Discussion Topics

Compelling Evidence

The HCPAC discussed requirements for compelling evidence and the validity or lack of validity of common arguments; e.g., incorrect assumptions made in previous valuation, evolution of technology and increased age and complexity of patients. The HCPAC also discussed the influence of electronic medical record keeping and its influence on professional service, discussing whether it is a change in workflow or actual work. CMS clarified that they do not make a determination on compelling evidence when evaluating the HCPAC recommendations.

Appeals Process

The HCPAC discussed that an appeal by a society may be based on a perceived problem with the process. The HCPAC also discussed that an appeal is different than a request for reconsideration of a recommended work value. Some HCPAC members suggested that this should be more explicitly outlined in the appeals process document currently found in RUC reference materials. It was recommended to request the Administrative Subcommittee to review the current language of this document and possibly provide more definitive language defining criteria for an appeal.

Lobbying Policy

The RUC Lobbying Policy was presented and discussed. It was recommended that if any member is contacted by a vendor or a device company to contact AMA staff immediately.

Work RVU Evaluation

The RVU work evaluation checklist was reviewed. As part of this discussion, the HCPAC discussed pre-facilitation options. The HCPAC discussed that pre-facilitation outlines the problems with a recommendation but not advice on how to fix the problems. Dr. Nikjeh stated that reviewer comments shared with the specialty societies prior to the meeting is an important HCPAC member responsibility and may serve as effective pre-facilitation. A conference call prior to the meeting may occur if reviewer comments and societies determine a need.

Direct Practice Expense Inputs Evaluation

Practice expense issues were discussed such as compelling evidence and duplicative PE inputs. It was noted that the Chair of the PE Subcommittee and HCPAC members on the PE Subcommittee can serve as a resource as societies prepare and/or evaluate the PE recommendations. . The HCPAC also discussed that it is very important for the specialties to provide paid invoices for any new supplies and equipment along with their recommendations.

AMA/Specialty Society RVS Update Committee **Tab 8**
Pulmonary Wireless Pressure Sensor Services
Facilitation Committee #3

Members Present: Doctors Christopher Senkowski (Chair), Jennifer Aloff, Scott Collins, David Hitzeman, Timothy Laing, Doug Leahy, Dee Adams Nikjeh, PhD, Norman Smith and Stanley Stead.

93XX1 Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional (Report 93XX1 only once per 30 days)

The Facilitation Committee reviewed CPT code 93XX1 and determined that the survey pre- and immediate post-service time seemed high and the recommended work RVU seemed low relative to other similar services. The Committee recommended a crosswalk to MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70 and 2 minutes pre-time, 15 minutes intra-service time and 3 minutes post-service time). **The Facilitation Committee recommends a work RVU of 0.70 and 2 minutes pre-time, 13 minutes intra-service time and 3 minutes post-service time for CPT code 93XX1.**

The Facilitation Committee recommends the direct practice expense inputs as revised by the Practice Expense Subcommittee.

AMA/Specialty Society RVS Update Committee **Tab 13**
Water Vapor or Steam Thermotherapy
Facilitation Committee #1

Members Present: Doctors Ezequiel Silva (Chair), Dale Blasier, Gregory DeMeo, Peter Hollmann, Gwenn Jackson, John Lanza, Walter Larimore, Julia Pillsbury, Gregory Przybylski, Marc Raphaelson, Timothy Tillo, DPM, Bob Zwolak

The Facilitation Committee reviewed the family of codes for Water Vapor or Steam Thermotherapy and determined appropriate crosswalks for each of the three codes as outlined in the comparison tables below.

The Facilitation Committee reviewed CPT codes 53850, 53852 and 538X3 and determined that while the intra-service time is less for CPT codes 53852 and 538X3, CPT code 53850 involves more lower intensity monitoring time and the other two include more intense activities (ie, active monitoring vs. actively operating). They also determined that 53850 has 10 minutes post-service time because a catheter is used while the latter two codes require 15 minutes of post-service time because there are actual punctures into the prostate and the patient must be monitored due to greater occurrence of post-procedure hematuria. Further, the Committee agreed that the addition of 5 minutes pre-service time for positioning the patient in the dorsal lithotomy position was appropriate for codes 53852 and 538X3. The third code in the family, 538X3, is the most intense because of potential injury to adjacent structures. The crosswalks codify the progressive intensity in this family of codes with IWPUT of 0.041, 0.071 and 0.085, respectively.

53850 Transurethral destruction of prostate tissue; by microwave thermotherapy

The Facilitation Committee reviewed CPT code 53850 and determined that the longer procedure should logically have the lowest IWPUT. The committee recommends a crosswalk to CPT code 33272 *Removal of subcutaneous implantable defibrillator electrode* (work RVU = 5.42 and 39 minutes pre-service time, 45 minutes intra-service time and 25 minutes immediate post-service time).

Source	CPT	IWPUT	RVU	Total Time	Eval	Position	SDW	Intra	Post	Visits
Crosswalk	**33272**	**0.054**	**5.42**	**151**	**33**	**1**	**5**	**45**	**25**	**½, 99238 1, 99213**
REC	**53850**	**0.041**	**5.42**	**147**	**17**	**1**	**5**	**45**	**10**	**3, 99213**

The Facilitation Committee recommends a work RVU of 5.42 and 23 minutes pre-service time, 45 minutes intra-service time and 10 minutes immediate post-service time and 3, 99213 visits for CPT code 53850.

53852 Transurethral destruction of prostate tissue; by radiofrequency thermotherapy

The Facilitation Committee reviewed CPT code 53852 and determined that, of the 41 survey respondents for CPT code 53852, 20 reported experience and 21 did not. The intra-service median time was 30 for both sets of respondents. The committee recommends a crosswalk to CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* (work RVU = 5.93 and 25 minutes pre-service time, 33 minutes intra-service time and 10 minutes immediate post-service time). The codes have the exact same total time and intra-service times are nearly the same.

Source	CPT	IWPUT	RVU	Total Time	Eval	Position	SDW	Intra	Post	Visits
Crosswalk	**67917**	**0.080**	**5.93**	**142**	**19**	**1**	**5**	**33**	**10**	**½, 99238 2, 99212 1, 99213**
REC	**53852**	**0.071**	**5.93**	**142**	**17**	**6**	**5**	**30**	**15**	**3, 99213**

The Facilitation Committee recommends a work RVU of 5.93 and 28 minutes pre-service time, 30 minutes intra-service time and 15 minutes immediate post-service time and 3, 99213 visits for CPT code 53852.

538X3 Transurethral destruction of prostate tissue; by radiofrequency- generated water vapor thermotherapy

Source	CPT	IWPUT	RVU	Total Time	Eval	Position	SDW	Intra	Post	Visits
Crosswalk	**67917**	**0.080**	**5.93**	**142**	**19**	**1**	**5**	**33**	**10**	**½, 99238 2, 99212 1, 99213**
REC	**538X3**	**0.085**	**5.93**	**137**	**17**	**6**	**5**	**25**	**15**	**3, 99213**

The Facilitation Committee reviewed CPT code 538X3 and emphasized that this code is the most intense in the family due to the use of hot water causing potential injury to adjacent anatomic structures. The committee recommends a crosswalk to CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* (work RVU = 5.93 and 25 minutes pre-service time, 33 minutes intra-service time and 10 minutes immediate post-service time).

The Facilitation Committee recommends a work RVU of 5.93 and 28 minutes pre-service time, 25 minutes intra-service time and 15 minutes immediate post-service time and 3, 99213 visits for CPT code 538X3.

The Facilitation Committee recommends the direct practice expense inputs as revised by the Practice Expense Subcommittee.

AMA/Specialty Society RVS Update Committee **Tab 15**
Contrast-Enhanced Ultrasound
Facilitation Committee #2

Members Present: Doctors Jennifer Wiler, MD (Chair), Margie Andreae, MD, James Blankenship, MD, Jimmy Clark, MD, Verdi DiSesa, MD, Alan Lazaroff, MD, Alnoor Malick, MD, Karen Smith MS, MBA, RD, LD, FADA, James Waldorf , MD, George Williams, MD

76X0X Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion

The Facilitation Committee reviewed CPT code 76X0X and determined that the survey median of 1.82 of overvalued the work of this service, however agreed that the survey 25th percentile of 1.27 undervalued the work of this service. The Committee also agreed that the recommended pre- and immediate post-service time was too high relative to other Radiology services. The specialty society revised their recommendation, decreasing the clinical staff time to 5 minutes pre-service time and 5 minutes immediate post-service time. The Committee recommended a crosswalk to CPT code 73719 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)* (work RVU = 1.62 and 5 minutes pre-service time, 20 minutes intra-service time and 5 minutes post-service time). **The Facilitation Committee recommends a work RVU of 1.62 and 5 minutes pre-service time, 20 minutes intra-service time and 5 minutes post-service time for CPT code 76X0X.**

76X1X Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion; each additional lesion with separate injection (List separately in addition to code for primary procedure)

The Facilitation Committee reviewed CPT code 76X1X and determined that the survey median of 1.10 overvalued the work of this service. The specialty society revised their recommendation to reflect the survey 25th percentile of 0.85 work RVUs and the Committee agreed that this accurately reflects the work value of this service. For additional support the Committee compared the survey code to MPC codes 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80, 15 minutes intra-service time) and 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)* (work RVU = 0.80, 15 minutes intra-service time). The survey code is appropriately valued higher because although there are efficiencies gained because it is the second lesion it still requires similar intra-service work to the base code as real time decision making is needed requiring the physician to remain in the room to review the detail of the images. **The Facilitation Committee recommends a work RVU of 0.85, the survey 25th percentile and 15 minutes intra-service time for CPT code 76X0X.**

The Facilitation Committee also discussed the new practice expense supply item, bubble contrast agent because a Committee member asked if it was possible to use saline rather than this fairly high cost supply. The society explained that agitated saline is only used in echocardiography to assess for a left to right shunt. When intravascular contrast is used in echocardiography, as in this procedure, it is the aforementioned lipid stabilized microbubble contrast agent. This is the only agent that is FDA approved for contrast enhanced ultrasound.